



ACCURATE ◊ ON TIME ◊ RESPONSIVE  
PRÉCIS ◊ À TEMPS ◊ FLEXIBLE

## Account Opening Form

### TO BE FILLED BY NEOPHARM LABS INC

ACCOUNT NUMBER	TERMS OF PAYMENT
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### COMPANY INFORMATION

Company Name:	Organisation of business : <input type="checkbox"/> CORPORATION <input type="checkbox"/> PARTNERSHIP
Name of the Owner(s):	<input type="checkbox"/> OTHER : _____
Telephone number:	Incorporation : <input type="checkbox"/> FEDERAL <input type="checkbox"/> PROVINCIAL
In business since : MONTH                      YEAR	<input type="checkbox"/> OTHER : _____

### INVOICING INFORMATION

### CERTIFICATE OF ANALYSIS INFORMATION

Billing Address:	Delivery Address* <input type="checkbox"/> Same as Invoicing
Address	Address
City	City
Province/State	Province/State
Country	Country
Zip/Postal Code	Zip/Postal Code
Invoicing Email(s):	COA email(s) :
Contact for Accounts payable:	Contact Information :
Accounts Payable Email:	Name
Head of Finance Contact:	Email
Head of Finance Email:	Title
Invoice Currency <input type="checkbox"/> CAD <input type="checkbox"/> USD	Telephone
Purchase Order Required <input type="checkbox"/> YES <input type="checkbox"/> NO	The services provided must be done according to: <input type="checkbox"/> CANADIAN GMP <input type="checkbox"/> U.S. GMP <input type="checkbox"/> _____ GMP <input type="checkbox"/> N/A
COA and invoicing Language:	<input type="checkbox"/> FRENCH <input type="checkbox"/> ENGLISH

**\*Delivery Address will determine taxes applicable**



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### BANK REFERENCE

NAME OF YOUR BANK	TRANSIT #	LINE OF CREDIT LIMIT
ACCOUNT MANAGER	ACCCOUNT #	PHONE
COMPLETE ADDRESS	ZIP/POSTAL CODE	

Any returned items during the past 12 months?  YES  NO

Any credit defaults during the past 12 months?  YES  NO

Ever filed for bankruptcy protection?  YES  NO

### SUPPLIER REFERENCE

1	NAME OF SUPPLIER	COMPLETE ADDRESS	
	CONTACT PERSON NAME	EMAIL FOR CONTACT**	PHONE NUMBER
2	NAME OF SUPPLIER	COMPLETE ADDRESS	
	CONTACT PERSON NAME	EMAIL FOR CONTACT**	PHONE NUMBER
3	NAME OF SUPPLIER	COMPLETE ADDRESS	
	CONTACT PERSON NAME	EMAIL FOR CONTACT**	PHONE NUMBER

**\*\* Email for contact must be provided**

### AUTHORIZATION OF CREDIT INQUIRY AND ACCEPTANCE OF SALE AND CREDIT CONDITIONS

*I hereby authorize NEOPHARM LABS INC., to conduct a credit assessment of our company including but not limited to requesting a credit history from applicable sources.*

*Terms of payment are: net 30 days, a service charge of 2% per month payable in respect of any account balance not paid. The customer hereby agrees to pay all collection costs and/or legal fees relating to this account if such measures are necessary due to non-payment.*

NAME AND TITLE	SIGNATURE
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PLEASE COMPLETE THIS FORM AND RETURN THE ORIGINAL SIGNED COPY OR A SCANNED ORIGINAL BY EMAIL