NHS Trust Hospital Credit Account Application Form 1/2

1	**Contact Name & Title**	
	Position	
	Department	
	Organisation Full Name	
	Full Address	
	Post Code	
	County	
	Country	
	Telephone No.	
	Mobile Telephone No.	
	Skype No.	
	Fax No.	
	Email Address	
	Website Address	
2	**Monthly Credit Limit Requested**	
3	**Account Department Contact**	
	Address (if different from above)	
	Post Code	
	County	
	Country	
	Telephone No.	
	Fax No.	
	Email Address	
	Email Address for Invoices	
4	**Purchasing Department Contact**	
	Address	Same as 1 ☐ Same as 3 ☐
	Post Code	
	County	
	Country	
	Telephone No.	
	Fax No.	
	Email Address	
	Valid Purchase Order number Required	Yes ☐ No ☐
	Format of Purchase Order Number	

NHS Trust Hospital Credit Account Application Form 2/2

Our Terms & Conditions are posted on our website (www.viamed.co.uk**), please read them thoroughly and sign below to accept them.**

Signature: .....

Print Name: .....

Title: .....

Date: .....

Please submit this form by email but also return your signed original application form (photocopies will not be accepted) to:

Viamed Ltd
15 Station Road
Cross Hills
Keighley
West Yorkshire
BD20 7DT
United Kingdom

Once received, we will process your application.