



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.