Existing Distributor Form

1	**Contact Name & Title**	
	Position	
	Department	
	Organisation Full Name	
	Full Address	
	Post Code (zip code)	
	County / Region	
	Country	
	Telephone No.	
	Mobile Telephone No.	
	Skype No.	
	Fax No.	
	Email Address	
	Website Address	
	Currency required	Euro € ☐ US Dollar $ ☐ UK Pound £ ☐
2	**VAT No.**	
	Company Registration No.	
	Nature of Business	
	Date Established	
	Type of Company	Limited ☐ Partnership ☐ Sole Trader ☐ PLC ☐ Other ☐ (please specify)……
3	**Account Department Contact**	
	Address (if different from above)	
	Post Code (zip code)	
	County / Region	
	Country	
	Telephone No.	
	Fax No.	
	Email Address	
	Email Address for Invoices	
4	**Purchasing Department Contact**	
	Address	Same as 1 ☐ Same as 3 ☐
	Post Code (zip code)	
	County / Region	

	Country	
	Telephone No.	
	Fax No.	
	Email Address	
5	**Insurance**	
	Do you have insurance to cover your order shipments from Viamed?	Yes ☐ No ☐
	Do you require insurance to be added by Viamed to all future orders and have insurance covered by UPS (charged at 1% of goods value, minimum £10.00/€11.50/$12.50)?	Yes ☐ No ☐

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

Signature: .....

Print Name: .....

Title: .....

Date: .....

Please submit this form via email to distributors@viamed.co.uk