**Client Account Form**

**Supply Details**

Establishment Name:

Address:

Establishment Type: Residential Home Nursing Home Hospital

Learning Disability Mental Health Day Centre

(If Other Please Specify):

Contact Name:

Position:

Contact Number:

Contact Email:

**Invoicing Details**

Contact Name:

Position:

Invoicing Address (if different):

Contact Telephone Number:

Contact Email Address:

Bank Account:

Sort Code:

 Account Number:

 Company Registration Number:

**By submitting this application, I certify that all the information I have provided is accurate and true to the best of my knowledge. I give Healthcare Direct permission to check and verify my credit history and bank information for the purpose of determining business relations. In addition, I understand that by completing and signing this form I acknowledge that I have received, read and understood Healthcare Directs’ Terms and Conditions and agree to abide by them**.

Client Signature: Client Name (in full): Date:

Registered in England No. 10212434 Healthcare Direct Services Ltd, 9 Romney Place, Maidstone, Kent, ME15 6LE