

Ph (604) 261-5057
Fax (604) 730-7186
Toll free 1-877-268-5057
order@promedics.ca



ProMedics Nutraceutical Ltd.
PO Box 155
2498 W 41st Ave
Vancouver BC
V6M 2A7

Practitioner Application Form

Date _____

Name: _____ **Clinic Name:** _____

Mail Address: _____ **Ship To (if different):** _____

City: _____ **City:** _____

Prov: _____ **Postal Code:** _____ **Prov:** _____ **Postal Code:** _____

Phone: _____ **Fax:** _____

Email: _____ **Web site:** _____

Contact Person: _____ **Office Hours:** _____

Education

School attended: _____ **Year Graduated:** _____

Professional Degree/Registration/Certification: _____

ND _____ **DC** _____ **MD** _____ **Other** _____

License/Registration/Certificate#: _____

PLEASE FAX/MAIL A COPY OF YOUR CERTIFICATE

Practice

Type of practice/specialties: _____

Number of health-care professionals in practice: _____

Do you sell other professional products? _____ **Brands?** _____

Payment terms desired:

Auto Visa/MC/Amex: _____ (2% discount on order when prepaid by credit card)

Credit card at time of purchase: _____ (credit card # not kept -2% discount on order)

Net 30 days: _____ (No discount on order)

ProMedics Nutraceutical Ltd. is committed to providing high-quality products, excellent service and education to support you and your patients. Thank you for taking the time to complete the application. **Do not hesitate to call if you have any questions.**