KDM PHARMA CREDIT APPLICATION FORM

c/o ANTAH BUMIMEDIC SDN BHD, NO.3, JALAN 19/1, 46300 PETALING JAYA

ACCOUNT NO : **KDM/XPCL :**

(Please provide a copy of the following documents and full information of the company to avoid any delay in processing)

FOR PRIVATE LIMITED ☐ PLEASE TICK		FOR SOLE PROPRIETOR/PARTNERSHIP ☐ PLEASE TICK	
1. CLINIC KKM LICENCE/ANNUAL PRACTICING CERTIFICATE		1. CLINIC KKM LICENCE/ANNUAL PRACTICING	
2. MEMORANDUM OF ARTICLES		CERTIFICATE	
3. FORM 24 & FORM 49			

DOCTOR'S NAME

BUSINESS (CLINIC) NAME

BUSINESS (CLINIC) ADDRESS

(RENTED/OWNED)

BUSINESS (CLINIC) REGISTR/APC NO

DATE OF INCORPORATION

YEARS IN BUSINESS

CONTACT PERSON FOR PAYMENT

TELEPHONE NO. **FAX NO**

HANDPHONE NO.

E-MAIL ADDRESS

PARTICULARS OF DIRECTORS/SHAREHOLDERS/PROPRIETORS/PARTNERSHIPS/DOCTORS

	NAME	I/C NO	HOME ADDRESS
1			
2			
3			

PARTICULARS OF BANKERS

	NAME & BRANCH	ACCOUNT NO	FACILITIES/B.G/O/D LIMIT
1			
2			

AUTHORISED SIGNATURES

	NAME	SPECIMEN SIGNATURE
1		
2		
3		

I/We declare that all the above information are correct. I/We hereby undertake and agree to pay for all medications purchased and invoiced, to KDM Pharma/Antah Bumimedic Sdn Bhd within the stipulated period of 60 days from the date of purchase.

(NOTE : All payments to be made in favour of 'ANTAH BUMIMEDIC SDN BHD'. A monthly 'Interest Charge' of 1.5% will be levied on all outstanding invoices after the stipulated period of 60 days.)

DOCTOR'S SIGNATURE & DATE	DESIGNATION/POSITION	BUSINESS (CLINIC) CHOP

FOR OFFICE USE ONLY

ACCOUNT INTRODUCED BY :

(KDM MEMBER's NAME) KDM No.	(Signature)	(Date)

APPROVED BY :

(KDM PHARMA CHAIRMAN)	(Signature)	(Date)

CREDIT LIMIT GRANTED : _____ **TERMS** **60 DAYS ONLY**

NEW ACCOUNT NO : **KDM/XPCL :**

OTHER REMARKS/COMMENTS : _____