OFFICE USE

Reg No:……

Date:…….

FIX PASSPORT PHOTOGRAPH

BIOMEDICAL LIMITED

CUSTOMER REGISTRATION FORM

FORM MS01

PART A

Corporate Name: ……..

Corporate Address: …….

Year of Incorporation/Establishment: ……..(Please attach photocopy certificate)

Director/Owner of Business (Full Name): ……

Residential Address of owner of Business (Not P.O. Box): .....

……

Residential Telephone Number/MD's GSM: ……..

Banker:……..

Bank Address: ……..

Form of Business: ……(Please state ownership)

(Sole/Partnership/Limited Liability)

What is your expected turnover of Biomedical Products in the next six(6) months?: …….

……

Other Companies already distributing for and Annual turnover in Naira terms

	COMPANY NAME	ANNUAL TURNOVER
(i)	……	……
(ii)	……	……
(iii)	……	……

PART B

CATEGORIZATION OF CUSTOMERS	**PLEASE TICK**
GOVERNMENT:	
PRIMARY- These are primary Health care centres Health units, Community clinics	
SECONDARY – These are generally Hospitals.	
TERTIARY – These are teaching Hospitals, FMC	
MINISTRY/PARASTATALS – Medicine are often ordered by Ministries, Parastatals like DFFRI, NDDC etc for distribution to several hospitals.	
PRIVATE HOSPITALS:	
BIG – 30 BEDS and above	
MEDIUM - BETWEEN 11-29 BEDS	
SMALL - BELLOW 11 BEDS	
DISTRIBUTORS:	
MAJOR – Large establishment with many outlets, big storage and sufficient capital(above 5million)	
SMALL - Growing, able to show capital availability between (2-5Million)	
PHARMACY	
WHOLESALER	
RETAILER	

PART C

(Please tick as appropriate where Yes or No)

PLEASE ATTACH COPIES OF THE EVIDENCE OF REGISTRATION AND LICENCE

Do you have registered Pharmacist in care of your Business? Yes No

Do you have a sales force to strengthen your redistribution network? Yes No

Do you condition the temperature of your storage system? Yes No

Do you have delivery vans for carrying your goods? Yes No

Do you have an efficient recording system for your day to day transaction? Yes No

What is the size of your warehouse/storage facility? …….

Is your storage space neat and tidy? Yes No

REFEREE

Give at least two(2) referees other than your banker that we can contact concerning you.

1. ……
2. ……

PART D

(Name and Address: Not P.O. Box Please)

I, Mr/Mrs/Miss ……. hereby declare that the above information is true and correct and the company has the right to withdraw my registration if discovered to be otherwise.

Name: ……

Designation: ……. Signature/Date: ……

Witness's Name: ……

Occupation: …… Rank: ……

Signature: …….. Date: ……

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Investigation officer: ……

Comment: ……..

……..

Sales Manager's Comment:

Do you consider the customer a proper company to be appointed as distributor? Yes/No.

(a) State Reason for your recommendation: ……
……
(b) Monthly target agreed with the distributor: ……
……

Signature of Sales Manager: …….. Date: ……

Marketing Manager's Comments/Recommendation: ……

……

……

Executive Director's Comment:

……
……

Executive Director's Signature: …… Date: ……