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GENERAL INFORMATION:

Name of Business (Legal Name): _____
Number associated with the enterprise (Central enterprise database/CCC): _____
Operating Name (If different): _____
Pharmacy/store owner: _____
Tel.: _____ Ext: _____ Fax: _____ Cell.: _____
Group Purchasing Organization (If applicable): _____
PO Number required: Yes No - Payment options: Net 30 days Credit Card

SHIP TO ADDRESS:

Business address: _____ Department: _____
City: _____ Province: _____ Postal Code: _____
Receiving hours: _____

BILL TO ADDRESS (If different than the ship to address):

Business address: _____ Department: _____
City: _____ Province: _____ Postal Code: _____

OTHER INFORMATION:

Store/Pharmacy email: _____
Purchasing Person #1: _____ Tel.: _____ Ext.: _____
Email: _____
Purchasing Agent #2: _____ Tel.: _____ Ext.: _____
Email: _____
Accounts Payable Contact #1: _____ Tel.: _____ Ext.: _____
Email: _____