



# Pharmacy Enrolment Form

## PROVIDER INFORMATION

<b>PHARMACY NAME</b>			
<b>ADDRESS</b>			
STREET		CITY	
PROVINCE	POSTAL CODE	UNIT #	
<b>TELEPHONE NUMBER</b>		<b>FAX NUMBER</b>	
<b>ACCREDITATION / LICENSE NUMBER</b>		<b>WEBSITE</b>	
<b>CONTACT PERSON</b>			
LAST NAME		FIRST NAME	
<b>POSITION</b>		<b>EMAIL ADDRESS</b>	
<b>DISPENSING FEE</b>		<b>OPENING DATE OF PHARMACY</b>	

## MODE OF PAYMENT

<input type="checkbox"/> Thru Manual Cheque		
<input type="checkbox"/> Thru Direct Deposit		
<b>BANK INFORMATION</b>		
NAME		
ADDRESS		
BANK ID	TRANSIT NUMBER	ACCOUNT NUMBER
I hereby authorize Esorse Corporation to credit/debit our account. This authorization may be terminated by either Esorse Corporation or by my organization through a prior written notice		
_____	_____	_____
Name	Signature	Date
<i>Authorized Representative</i>		

## STATEMENTS

I would like to receive my statements via :	
<input type="checkbox"/> Email	<b>Please check this box if you would like to receive emails from Esorse Corporation as we need your express consent to send any commercial electronic messages to your email address</b>
<input type="checkbox"/> Fax	
<input type="checkbox"/> Do not send	

## HOURS OF OPERATION

	MODE	TIME FROM (hh:mm am/pm)	TIME TO (hh:mm am/pm)
Monday		:	:
Tuesday		:	:
Wednesday		:	:
Thursday		:	:
Friday		:	:
Saturday		:	:
Sunday		:	: