



NEW ACCOUNT FORM

Name of Licensed Practitioner: \_\_\_\_\_ Degree \_\_\_\_\_

Professional Title of Practitioner (circle one): MD DC LAC DO DDS OD RPH ND DVM RD LMT PT RN LPN PHD Other \_\_\_\_\_

Shipping Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Billing Address (if different): \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

E-mail Address: \_\_\_\_\_

Website: \_\_\_\_\_

Telephone Number ( ) \_\_\_\_\_ Fax Number ( ) \_\_\_\_\_

Office Hours: Mon. \_\_\_\_\_ Tues. \_\_\_\_\_ Wed. \_\_\_\_\_ Thurs. \_\_\_\_\_ Fri. \_\_\_\_\_ Sat. \_\_\_\_\_

\*\*\* Please complete the following required forms and fax to (407) 445-0204 \*\*\*

- New Account Form (This form filled out.)
□ Customer Protection Agreement (Completed, signed and dated.)
□ Copy of current State Practitioner's License (MD, DC, LAC, DO, DDS, OD, RPH, ND, DVM)
□ Copy of current Business License (Only for RD, LMT, PT, RN, LPN, PHD or any other profession not listed above.)

Optional:

- Set up my account to allow patient-direct ordering. (Submit completed Form W-9; download from www.irs.gov.)
□ To allow patients the option of ordering online through the XYMOGEN eStore, please create a Referral Code that you will provide to your patients to access online ordering. Any combination of alpha and/or numeric characters, with a min. of 1 and a max. of 30 characters.:

Important! To avoid unnecessary delays in opening your account, we require all documents listed above. The Customer Protection Agreement must be signed, dated and filled out in its entirety. Any missing documents will delay your wholesale account from being established. Please contact the New Accounts Department if you have any questions.

So we may better assist you, please complete the following:

How did you hear about us? \_\_\_\_\_

Is there another address where your practice is located? □ Yes □ No

Who is your primary order contact person? \_\_\_\_\_

Are you currently providing nutritional supplements to patients? □ Yes □ No

If not, do you advise your patients about nutrition? □ Yes □ No

Which name brands do you presently carry? \_\_\_\_\_

Preferred method of payment: □ Visa □ MasterCard □ American Express □ Discover □ COD

Credit Card #: \_\_\_\_\_ Exp.: \_\_\_\_ / \_\_\_\_ (optional at this time)

Please check areas of interest: □ Detox □ Diagnostics □ Digestion □ Herbs □ Weight Loss

□ Female Health □ Musculoskeletal □ Other \_\_\_\_\_

Please name three of the most common conditions you address regularly in your practice:

\_\_\_\_\_

Comments/Requests: \_\_\_\_\_

Your account confirmation will be sent via □ fax or □ e-mail within 1 to 2 business days, and your XYMOGEN Welcome Packet will be sent by standard mail.

For Internal Use Only: FMC: \_\_\_\_\_ Customer ID: \_\_\_\_\_ Date Opened: \_\_\_\_\_