SUPPLIER / WHOLESALE CUSTOMER APPROVAL FORM

Data Validity: ***Only valid when both pages are presented together as one document and declaration has been signed***

COMPANY INFORMATION			
Company Name:		**Trading Name:** *(if different)*	
Company Registration Number:		**VAT Registration:**	
Supplier type	Select Select	Specify *(other)*: Specify *(other)*:	
Product type	Select Select Select	Specify *(other)*: Specify *(other)*: Specify *(other)*:	
Address	Registered:		
	Trading: *(if different)*		
	Warehouse:		
Transportation	Method:	Name:	

Site ID		**Site ID**		**Site ID**		**Site ID**		**Site ID**	
Site ID		**Site ID**		**Site ID**		**Site ID**		**Site ID**	
Site ID		**Site ID**		**Site ID**		**Site ID**		**Site ID**	
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Site ID		**Site ID**		**Site ID**		**Site ID**		**Site ID**	
Site ID		**Site ID**		**Site ID**		**Site ID**		**Site ID**	

CONTACT INFORMATION			
Name:		Name:	
Position:		Position:	
Phone:	Fax:	Phone:	Fax:
E-mail:		E-mail:	

LICENCE/ MEMBERSHIP INFORMATION *(complete as applicable)*		
Licence Type:	Select	Licence Ref No.:
	Select	Licence Ref No.:
	Select	Licence Ref No.:
	Select	Licence Ref No.:
	CD Schedules: ☐ 1 ☐ 2 ☐ 3 ☐ 4 (Part I) ☐ 4(Part II) ☐ 5	Licence Ref No.:
	☐ POM ☐ P ☐ GSL ☐ AVM-GSL ☐ NFA-VPS ☐ POM-VPS ☐ POM-V ☐ OTHER	
	Authorised to supply cold chain medicinal products: ☐ Yes ☐ No	
Certificate Type:	Select Issuing Authority: Certificate No.: Issue/ Inspection Date:	Validity Ends: *(No. of years permitted to be relied upon)*
	Select Issuing Authority: Certificate No.: Issue/ Inspection Date:	Validity Ends: *(No. of years permitted to be relied upon)*
	Select Issuing Authority: Certificate No.: Issue/ Inspection Date:	Validity Ends: *(No. of years permitted to be relied upon)*

Note: Mention 'Various' in the fields for Certificate No., Issue/ Inspection Date, and Validity Ends if there is more than one site.

Member of a trade association: ☐ Yes ☐ No Name of the association:

FMD Status: ☐ MAH ☐ Designated Wholesaler ☐ NA

Please send a copy of full current licence(s) as completed above and include the certificate for all authorised and nominated sites for supplying medicinal goods to Lexon UK. Send these documents by e-mail or fax (+44 1527 505 401). Please send an official English translation where originals are *not* in English.

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COMPANY INFORMATION	
Company Name:	**Trading Name:** *(if different)*

FINANCIAL INFORMATION			
Payment terms:	Freight and Insurance terms *(for UK suppliers)*:		
Retention of Title Policy:			
Bank Name:	Sort Code:	A/C No.:	
IBAN No.:	BIC/ SWIFT No.:		
Bank Address:		Country:	
Preferred address for the financial correspondences:			

Declaration: I/ We hereby declare that the above information is correct and true at the time of signing this document. I/We undertake responsibility of the mandate to notify ***Lexon UK*** as soon as practicable for any changes in the current status of the authorisation(s).

Name:	Signature:	Date:

APPROVAL *(to be completed by Lexon UK)*

Copy of all relevant authorisations/ licenses and Certificates received: ☐ YES ☐ NA

Controlled Drug Schedules Verified Against Licence (UK): ☐ 1 ☐ 2 ☐ 3 ☐ 4 (Part I) ☐ 4 (Part II) ☐ 5

Controlled Drug Schedules Verified Against Licence (Europe): ☐ Psychotropic / Narcotic

Authorised Legal Categories: ☐ POM ☐ P ☐ GSL ☐ AVM-GSL ☐ NFA-VPS ☐ POM-VPS ☐ POM-V ☐ OTHER

Cold Chain Medicinal Products: ☐ YES ☐ NO

If selected 'NA' above provide the reason:

An official English translation of the original documents received: ☐ YES ☐ NA *(original documents are in English)*

Credit Check *(for UK suppliers)*: ☐ YES ☐ NO ☐ NA

Company House *(for UK suppliers)*: ☐ YES ☐ NO

Any other checks: ☐ YES ☐ NO Specify:

Details Verified: ☐ YES Verified against:

Verified by:	Signature:	Date:

Provide this form and all associated documents including the evidence for the verification where appropriate to the RP. The suppliers of pharmaceutical raw materials are to be authorised by the QA Manager.

Authorisation: *(to be completed by RP / WQP or QA)*	Reviewed authorisation(s)/ licence(s): ☐ YES ☐ NA
	Reviewed GMP/ GDP certificate: ☐ YES ☐ NA
	Reviewed ISO certificate: ☐ YES ☐ NA
	FMD Status: ☐ MAH ☐ Designated Wholesaler ☐ NA
	Reviewed verification documentation: ☐ YES ☐ NA *(comment is required)*
	☐ Approved ☐ Declined
	Comments: *(if any)*
	Name: Signature: Date:

Added the supplier to Navision: ☐ YES ☐ NO *(provide reason)*:

Added on: Added by: Signature: