ECZANES
PHARMACEUTICALS

Client Onboarding Form

*(Fields marked * are mandatory. Application will not be processed if not completed)*	
CLIENT DETAILS	
*Company Name:	*Health Practitioner Name:
*Trading Name:	*AHPRA No.:
*ABN:	*ACN: (if applicable)
*Street Address:	*Postal Address:
*State:	*Post Code:
*Company Phone Number:	Company Fax Number:
Company Website:	
CLIENT CONTACT DETAILS	
* Accounts Contact Name:	*Accounts Contact Phone:
*Accounts Contact Phone:	*Accounts Fax:
*Accounts Contact Email:	
BANK DETAILS & OTHER REQUIREMENTS	
* Bank Name:	* Account Name:
* Address:	
* BSB:	* Account Number:
* Remittance Email:	
SUPPORTING DOCUMENTATION	
* Copy of APHRA Certificate	Attached: (YES) or (NO)
* Copy of Covid Plan	Attached: (YES) or (NO)

PLEASE EMAIL TO:
orders@eczanes.com.au

OFFICE USE ONLY:	
Client Number:	Date:
Requestor’s Name:	
Blanket PO No:	