ICM
DISTRIBUTING COMPANY

Drug Wholesaler
Authorization Form

Fax To: 800-958-3294
Email To: Katie@icmint.com
Questions?
Call 800-848-9692
Extension-189

Customer Name:_____

Owner:_____

Contact:_____

Phone #:_____ Fax #:_____

Email Address:_____

Salesperson:_____

Ship To:_____

_____

_____

_____

DRUG WHOLESALER BILL THRU INFORMATION:

Drug Wholesaler Name:_____

Drug Wholesaler Division:_____

Drug Wholesaler Account #:_____

Drug Wholesaler Consultant:_____

Business Sales Tax #_____

Corporate Name:_____

Authorized Signature:_____

Date:_____

TO BE COMPLETED BY ICM PERSONNEL

Price Tickets: YES ____ NO ____ Retail: ICM ___ SPEC _____

Break Pack: YES _____ NO_____