



Please FAX completed form to:
 Wyeth Pharmaceuticals
 Customer Information Group
 P.O. Box 1773
 Paoli, PA 19301-1773
 484 563-0060 (fax)

Customer Account Application

Healthcare Practitioner General Account Information

Section I Account Information

Account Name (If group practice or clinic)

Physician Name

Address Suite#

City State Zip Code

Contact Name

Telephone Number Fax Number

E-Mail Address

Section II Billing Information (If different from Section I)

Billing Account Name

Billing Address

City State Zip Code

Contact Name

Telephone Number Fax Number

Do you agree to be contacted by: Fax Email

Do you require a purchase order number? Yes No

Would you like to receive product updates from Wyeth? Yes No

Section III Nature of Business

Is this a consulting office? Yes No

Do you perform invasive procedures? Yes No

Are you part of a group practice or a single practitioner? Single Group

Group Practice Name

Section IV Licensure and Identifiers

Will you purchase directly from Wyeth? _____ If no, who is your primary wholesaler? _____

Customer Account Application (continued)

State License Number State Expiration Date (mm/dd/yy)

HIN Number DEA Number Expiration Date (mm/dd/yy)

IRS Employee Tax ID: _____ (if applicable)

Is this account exempt from sales and use tax? Yes No

State Tax Exemption Number **(Photo copy of State Exemption required)**

Section V Certification

By signing below, I certify that the information provided above is true and correct to the best of my knowledge, information and belief, made after diligent inquiry and that I am authorized to sign on behalf of applicant.

Signature Title Date (mm/dd/yy)