American Pharmaceutical Distributors®
Human Health Matters®

Pharmacy Customer Agreement

VERIFY INFORMATION INITIAL, SIGN AND EMAIL TO APP@AmericanAPD.com

* - Required Information

FDA Registered I **DEA** Registered | **BOP** Licensed | **Dept. of Health** Registered | **DSCSA** Compliant I **NABP** Accredited Distributor

American Pharmaceutical Ingredients, LLC (API) D.B.A. American Pharmaceutical Distributors (APD)

PAYMENT OPTIONS AND METHODS

*Do you prefer a credit limit of _____ with ____ day terms? ☐	*Regardless of payment method Section A, B and C of this page are required
*Do you prefer to pay-at-order? ☐	

*Primary Payment Method:	ACH Pull: ☐	Credit Card: ☐
*Secondary Payment Method: *(must be different than primary)*	ACH Pull: ☐	Credit Card: ☐

A. ACH AUTHORIZATION

ACH Authorization must be in the name of the owner or authorized agent of the pharmacy business. A one-time $1 test charge may be run and will be refunded.

I _____ (Type Name) hereby authorize Amerian Pharmaceutical Ingredients, LLC dba American Pharmaceutical Distributors ("APD") to maintain a secure record of my financial institution information and to ACH debit my account for products ordered and delivered to my pharmacy according to my approved credit terms, limits, and approved payment methods. I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify APD in writing of any changes in my account information or termination of this authorization. I understand that because these are electronic transactions, these funds may be withdrawn from my account as soon as invoices become due, without prior notice. I certify that I am an authorized user of this bank account and will not dispute these transactions with my bank so long as the transactions correspond to the indicated terms.

Name:	Signature:	Date:

B. CREDIT CARD AUTHORIZATION

Required Information: Credit Card must be in the name of the owner or authorized agent of the pharmacy. A new credit card authorization form is required for each credit card used. A one-time $1 test charge may be run and will be refunded.

*Card Holder Name:		*Legal Business Name:		
*Card #:			*EXP:	*CVV:
VISA ☐	Mastercard ☐	Amex ☐	Discover ☐	Debit ☐
*Billing Address:				*Zip Code:

I _____ (Type Name) hereby authorize Amerian Pharmaceutical Ingredients, LLC dba American Pharmaceutical Distributors ("APD") to maintain a secure record of my credit/debit card information and to debit my account for products ordered and delivered to my pharmacy according to my approved credit terms, limits, and approved payment methods. I agree to make payments on-time and according to the terms on my invoice(s) for products ordered and received. I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify APD in writing of any changes in my account information or termination of this authorization. I understand that because these are electronic transactions, my card may be charged as soon as invoices become due, without prior notice. I certify that I am an authorized user of this credit card account and will not dispute these transactions with my credit card company so long as the transactions correspond to the indicated terms.

*Card Holder Signature:	Date:

C. FINANCIAL INSTITUTION

Financial institution account must be in the name of the owner, authorized agent, or pharmacy business. Our financial compliance policies require a voided check to verify your routing and account number.

*Financial Institution:	*Account Name:
*9-Digit Routing #:	*Account #:
*Financial Institution Address:	*Zip Code: