NORTHPOINT

Downlands College Students

APPLICATION FOR 30 DAY ACCOUNT

PARENT'S NAME/S:_____

ADDRESS:_____

PHONE No.: (H) _____(W)_____

OCCUPATION:_____

EMPLOYER NAME & ADDRESS:_____

DRIVER'S LICENCE No.:_____

STUDENT'S NAME/S:

_____Pension No.(If Applicable)_ _ _ _ _ _ _ _ _ _ _ _ _ _ _

_____Pension No.(If Applicable)_ _ _ _ _ _ _ _ _ _ _ _ _ _ _

_____Pension No.(If Applicable)_ _ _ _ _ _ _ _ _ _ _ _ _ _ _

General Terms and Conditions

1. I/We understand and acknowledge that this account will be used for any items requested by the **Downlands College Health Centre.** Approval for any items using this account **NOT** requested by the Downlands College Health Centre must first be obtained by a parent or guardian **PRIOR** to this purchase.
2. I/We understand and acknowledge that normal trading terms are **strictly 30 days** and that payment is due by the 30th day of the month following the month in which charges are debited to the account
3. I/We undertake to pay all accounts on or before the due date and acknowledge that should payment become overdue, credit may be withdrawn at any time.
4. I/We understand that credit may be withdrawn at any time.
5. **I/We understand that an administration fee of $2.50 per calendar month may be charged on any account with overdue amounts.**
6. I/We agree to pay any reasonable expenses incurred in obtaining or attempting to obtain payment of any overdue amount.
7. I/We understand that credit will be suspended if any amounts become overdue.

Priceline Pharmacy Northpoint reserves the right to vary the Terms and Conditions at any time by giving 30 days prior notice to the costumer.

SIGNED:_____DATE:_____

NAME (PLEASE PRINT):_____

Both Forms must be completed in full and returned before account can be used.

Priceline Pharmacy Northpoint, Shop 21 Northpoint Shopping Centre, 125 Ruthven Street, Toowoomba QLD 4350
Ph. (07) 46327172 Fax (07) 46393225

Dear Parent

As of May 1st, 2002 it is necessary for pharmacy to submit your current Medicare details each time a NHS script is dispensed. To aid in this process could you please present your current Medicare Card to the pharmacy or complete the form below.

Each time a new Medicare card is issued, we need to update these details.

Please Note: It is important to record details *exactly* as they appear on your card.



Medicare Number: __ __ __ __ __ __ __ __ __ __

Position Number and Name of Student : __ _____
(Name must be recorded *exactly* as it appears on the card)

Position Number and Name of Student : __ _____
(Name must be recorded *exactly* as it appears on the card)

Position Number and Name of Student : __ _____
(Name must be recorded *exactly* as it appears on the card)

Card Expiry Date: _____/20_____

*** Medicare will not permit us to dispense at the concessional rate without the *current* Medicare Number**