Terms and Conditions

_____licensed in the Province of Manitoba by the College
Pharmacy Name

of Pharmacists of Manitoba License #: _____ ("Pharmacy")

Pharmacy Address: _____ Tel: _____

_____ Fax: _____

-and-

CPM – The Compounding Pharmacy of Manitoba
License #33859
27047 Oakwood Road, Oakbank MB R5N 0A6
Tel: 204-444-4955 Fax: 204-444-4754

The Pharmacy hereby agrees to the Terms and Conditions for pharmacy services as identified by The Compounding Pharmacy of Manitoba which shall in turn be subject to the rules and regulations as set forth by the College of Pharmacists of Manitoba and Health Canada.

The Pharmacy agrees to pay for the product and services provided by The Compounding Pharmacy of Manitoba as identified below (select one):

☐ Visa/Mastercard – Must complete authorization form on page 2

☐ Direct Payment (EFT) – Must complete authorization form on page 3

_____ _____
Name *Please Print* (as per pharmacy) **Signature (as per pharmacy)**

_____ _____
Title (Owner or Pharmacy Manager) **Date**

*****AGREEMENT MUST BE SIGNED BY THE PHARMACY MANAGER OR PHARMACY OWNER*****

_____ _____
Name *Please Print* (as per CPM) **Signature (as per CPM)**

Payment Authorization Credit Card

Pharmacy Name:_____

Credit Card (only Visa and Mastercard are accepted)

☐ Charge credit card for each order

☐ Charge credit card at end of month for all orders

Visa / Mastercard (please circle ONE)

Name on Credit Card: _____

Credit Card Number: _____

Expiration Date: _____

Security Number (3-digit): _____

_____ _____

Name (please print) **Signature**

_____ _____

Title **Date**

The Compounding Pharmacy of Manitoba
27047 Oakwood Rd 64N, Oakbank, MB R5N 0A6
Email: accounting@pharmacymanitoba.com

Business Pre-Authorized Debits (PAD)

Direct Payment (Electronic Funds Transfer) – Please provide a copy of a VOID cheque

Direct payment will occur at the end of each month for all orders processed during the month. An invoice will be provided detailing the PAD payment.

Pharmacy Name (Payor): _____

Email: _____

Banking Information:

Vendor's Bank Address: _____ Telephone:_____

_____ Fax: _____

_____

Bank Account Number: _____

Bank Branch Number (5-digits): _____

Bank Transit Number (3-digits): _____

I hereby authorize payment for all products and services provided by The Compounding Pharmacy of Manitoba.

_____ _____
Name (Please Print) Signature

_____ _____
Title Date

Cancellation

The Payor may revoke their authorization at any time, subject to providing notice at least 30 days in advance of the cancellation. The Payor may obtain a sample cancellation form, or further information on their right to cancel a PAD Agreement, at their financial institution or by visiting www.payments.ca.

Recourse/Reimbursement

The Payor has certain recourse rights if any debit does not comply with this agreement. For example, you have the right to receive reimbursement for any debit that is not authorized or is not consistent with this PAD agreement. To obtain more information on your recourse rights, contact your financial institution or visiting www.payments.ca.

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