

## Dr. Scabies® - Wholesale Account Application

Please note: In order to process your application, a signature must be provided and all fields must be filled in. Use N/A if question does not apply. Along with this form, a completed Wholesale Contract is required.

### COMPANY INFORMATION

|   |                                       |                                       |                 |
|---|---------------------------------------|---------------------------------------|-----------------|
| COMPANY NAME                                |                                       |                                       |                 |
| EMAIL                                       |                                       | WEBSITE                               |                 |
| PHONE NUMBER                                |                                       | FAX NUMBER                            |                 |
| BILL TO ADDRESS                             |                                       | CITY                                  |                 |
| STATE                                       | ZIP                                   | COUNTRY                               |                 |
| SHIP TO ADDRESS                             |                                       | CITY                                  |                 |
| STATE                                       | ZIP                                   | COUNTRY                               |                 |
| DELIVERY HOURS                              | RECEIVER/WAREHOUSE CONTACT            |                                       | CONTACT PHONE   |
| BUSINESS STRUCTURE                          | RETAIL STORE<br><input type="radio"/> | ONLINE STORE<br><input type="radio"/> | OTHER STRUCTURE |
| TAX ID                                      |                                       |                                       |                 |
| BUYER'S NAME                                |                                       | BUYER'S PHONE                         |                 |
| ACCOUNTS PAYABLE CONTACT                    |                                       | ACCOUNTS PAYABLE PHONE                |                 |
| CURRENT BROKER/BROKER GROUP (IF APPLICABLE) |                                       |                                       |                 |

**RETAIL STORE INFORMATION**

|                 |     |         |       |
|-----------------|-----|---------|-------|
| STORE ADDRESS 1 |     | CITY    |       |
| STATE           | ZIP | COUNTRY | PHONE |
| STORE ADDRESS 2 |     | CITY    |       |
| STATE           | ZIP | COUNTRY | PHONE |
| STORE ADDRESS 3 |     | CITY    |       |
| STATE           | ZIP | COUNTRY | PHONE |

**ONLINE STORE\* INFORMATION (IF APPLICABLE)**

|     |     |
|-----|-----|
| URL | URL |
| URL | URL |

\*All online stores must be authorized and a contract with MAP policy must be signed. Dr. Scabies® will terminate the sale of its products to any retailer that does not comply with these terms and conditions.

Please note: We do not allow repackaging of any Dr. Scabies® products.

Would you want to be included on our online store locator page?      YES      NO  
     

|              |      |
|--------------|------|
| PRINTED NAME |      |
| SIGNATURE    | DATE |