



Wyeth is a wholly owned subsidiary of Pfizer, Inc

Please FAX completed form to:  
Wyeth Pharmaceuticals  
Account Compliance and  
Communications  
P.O. Box 1773  
Paoli, PA 19301-1773  
(484) 563-0060

## Customer Account Application Healthcare Practitioner General Account Information

### Section I Account Information

### Section II Billing Information (If different from Section I)

Account Name (If group practice or clinic)

Billing Account Name

Physician Name

Billing Address

Address Suite#

City State Zip Code

City State Zip Code

Contact Name

Contact Name

Telephone Number Fax Number

Telephone Number Fax Number

Do you agree to be contacted by: Fax Email

E-Mail Address

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? \_\_\_\_\_

Please include all licenses related to this location.

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Class (type) of license:

**(Photo copy of license required)**

**Customer Account Application (continued)**

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State License Number

State

Expiration Date (mm/dd/yy)

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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

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State Tax Exemption Number

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

**Section V Certification**

**I certify that the above information is true and correct to the best of my knowledge, information and belief, made after diligent inquiry.**

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Signature

Title

Date (mm/dd/yy)