

New Account Application

Thank you for your interest in our products. We look forward to learning more about your business. Please assist us in creating a profile for you by providing us with the following information:

Company Name _____

Principle Contact Name(s) _____ Title _____

Shipping Address _____

City _____ State _____ Zip _____

Billing Address (if different) _____

City _____ State _____ Zip _____

Phone # _____ Fax # _____

E-Mail _____ Website _____

Billing Contact Name _____ Email _____

What is the primary nature of your business at this location? (Circle more than one if applicable)

Health Food Store Pharmacy Clinic/Practice Sports Med Mail Order Ecommerce
Manufacturer Export Distributor Other _____

Practitioner Type: MD DC ND CNHP LMT DPHARM OTHER _____

How did you hear about us? _____

What inspired you to pursue a wholesale account? _____

Do you have any additional questions or comments? _____

Please fax, email, or mail a completed wholesale application with a copy of your business, resale, or professional license to (716) 373-5193, or info@AlleganyNutrition.com. Verified wholesale accounts are normally established within 1 business day. Please contact our office directly with any questions 1-800-587-9061.

Mailing Address:
Allegany Nutrition
P.O. Box 70
Allegany, NY 14706