Customer #_______________

Experts in Blood Pressure Management™

PharmaSmart®

PharmaSmart International Inc.

EFT Information Request

Customer Name: ____

Customer Address: ____

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Telephone Number: _________________________

Fax Number: _________________________

Contact Person: _________________________

Email Address: _________________________

Banking Information: (Please attach a voided check):

Bank Name: ______________________

Routing Number: ______________________

Bank Account Number: ______________________

Bank Account Type: ______________________

EFT Transfer Type (Circle One): Recurring Payment One-Time Payment

I hereby authorize Pharma-Smart International Inc. to debit my account by EFT from the bank account named above. I am aware that my account will be debited with the first 7-10 business days of each month.

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Name of Authorized Person and Title (Please Print)

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Authorized Signature

____

Date

Please forward completed form and voided check by fax to (585) 427-8165 or by e-mail to accountsreceivable@pharmasmart.com.