

The undersigned wishes to become a member of WESTERN DRUG DISTRIBUTION CENTER LIMITED, a co-operative incorporated under "The Co-operative Associations Act" and continued under the Cooperatives Act of the Province of Alberta and hereby subscribes for and agrees to take up one share in WESTERN DRUG DISTRIBUTION CENTER LIMITED at a price of ONE THOUSAND (\$1,000.00) DOLLARS per share.

The undersigned has read the qualifications for membership listed and subject to this application being approved represents that he/she otherwise meets the requirements of members and agrees to abide by the qualifications of membership as provided in the By-laws of WESTERN DRUG DISTRIBUTION CENTER LIMITED.

DATED this, _____ day of _____ 20____

LEAD PRACTICE INFORMATION

Legal Business Name: _____ Business/GST Number: _____

Actual Clinic Name: _____

Address _____

City: _____ Postal Code: _____

Telephone Number: () _____ Fax: () _____

Business Email: _____ Clinic contact: _____

Shipping Preference: Purolator Loomis

PRINCIPAL(S) / OFFICER(S)

Last Name	First Name	Title/Position	%Ownership	Provincial License #
1. _____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____

BUSINESS INFORMATION

Year Business Started: _____(YY)

Year Present Ownership Established: _____(YY)

Ownership Type: Corporation Partnership Proprietor Other (specify)

Clinic Type: LA CA MA (____% CA ____% LA) Other (specify)

Practice Management Software: _____

Internet Capable: Yes No

Expected Monthly Purchases: _____ Expected Yearly Purchases: _____



BANK REFERENCE

Name of Bank: _____

Phone #: () _____ Fax #: () _____

Branch Location: _____ City: _____ Province: _____

Contact Name: _____

Credit References

Company Name	Address	City	Province	Telephone #
1. _____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____

***ALTERNATE SHIP TO SITE(S) INFORMATION (if applicable)**

(These are shipping addresses; the name of these practices will appear second to the lead practice. To be considered for an alternate 'ship to' site, the practice(s) **MUST** share the identical ownership structure as the lead practice.)

Legal Business Name : _____

Other Trade Name(s) : _____

Address: _____

City : _____ **Postal Code:** _____

Telephone Number : () _____ **Fax:** () _____

Business Email: _____

Business Information

Year Business Started: _____(YY)

Year Present Ownership Established: _____(YY)

Ownership Type: Corporation Partnership Proprietor Other(specify)

Clinic Type: LA CA MA (____% CA ____%LA) Other (specify)

Practice Management Software: _____

Internet Capable: Yes No

- **NOTE: THIS INFORMATION MUST BE COMPLETED FOR EACH MULTIPLE SHIP TO SITE**



I agree to abide by the terms and conditions listed in this Application and those that from time to time may be set forth in the WDDC catalog. I authorize WDDC to obtain all credit and other necessary personal information from credit agencies and veterinary associations that it deems necessary and to share such information with credit agencies and veterinary associations in order to accept this Application and in order for WDDC to continue to supply product to me.

I further authorize WDDC to collect, use and disclose information about the products purchased by me, for the purposes of: a) establishing and maintaining effective responsible relations with customers and veterinary associations; b) understanding customers' needs and preferences for their future products/service requirements to ensure adequate supplies of inventory from suppliers/manufacturers; c) ensuring customer information is accurate and up-to-date in order to continue providing them with ongoing products and services; d) protecting each of us against error or fraud; e) developing, marketing and enhancing products and services to customers; and f) as required by law.

All information pertaining to credit card, social insurance and home phone numbers will be held in secure location within WDDC

Payment Terms

Orders placed between the 1st to the 15th of any given month are due the end-of-the-month.

Orders placed between the 16th to the 30th of any given month are due on the 15th of-the-following-month.

WDDC statement periods are the 15th and the last day of every month.

Title does not pass from WDDC until merchandise is paid for.

Regardless of the location to which orders filled by WDDC may be delivered, the legal entity identified as the Lead Practice on this Application will be solely liable to WDDC for payment of all orders filled by WDDC. It is the responsibility of the applicant to advise WDDC of any change of ownership of any alternate site.

A prompt payment discount of 1.00% (before GST) is given to members that are current and pay within WDDC terms.

Any accounts that have a balance in excess of 30 days will incur a 0.75% interest charge per statement period (19.64% per annum). Shipments on past due accounts will be put on hold until payment arrangements have been made. Any charge backs are subject to a \$25.00 service charge.

Authorized Signature(s) _____

Attached to this Member Application are

- o Current Certificate of Incorporation
- o Cheque for Share amount of \$1,000 (*see Option A*)
- o Please apply \$1,000 share payment (plus service fee) to my VISA / MASTER CARD (*see Option A*)
- o I wish to apply accrued dividends based on my purchases through WDDC to my \$1,000 share (*see option B*) signed copy attached
- o I wish to have 26 payments of \$43.86 applied to my statement for payment of the \$1,000 share (*see option C*) signed copy attached

All options are pending WDDC Board of Director approval and may be reversed, changed or rejected please refer to WDDC by-laws enclosed in member package

**OPTION A – share payment via Cheque or credit card
DIRECT PAYMENT TO ACQUIRE A SHARE IN
WESTERN DRUG DISTRIBUTION CENTER LIMITED**

Enclosed please find our cheque in the amount of \$1,000 payable to Western Drug Distribution Center Limited

Please apply \$1,000 for the WDDC Share to the indicated credit card

Date _____

Clinic Name _____

Card Holder Name _____

My VISA® # _____ / _____ / _____ Exp. ____ / ____

My MASTERCARD® # _____ / _____ / _____ Exp. ____ / ____

Presently MASTERCARD® charges you a rate of 1.92% and VISA® charges 1.82% these service fees will be in addition to the \$1,000 share amount

Signature

Date

I agree to the above terms and authorize WDDC to charge \$1,000 (plus fees) only to the above Card Number. I understand these rates/policies are subject to change based on rates charged and policies in effect by the merchant financial institutions. These may change with or without notice.

**OPTION B – Share procurement through patronage
PROMISSORY NOTE TO ACQUIRE A SHARE IN
WESTERN DRUG DISTRIBUTION CENTER LIMITED**

The intent of this note is to enable you to enjoy all the benefits membership brings without the initial \$1,000.00 investment outlay. This note will be used to authorize Western Drug Distribution Center Limited to obtain the sufficient funds necessary to purchase one common share by using the patronage allocations you will earn while you are a member. Upon approval of your application for membership, you will have immediate access to the following shareholder privileges:

- 1 vote per common share
- Annual dividends based on your purchases
- Value Pack Pet food pricing
- Affinity programs
- Case lot discount program
- Waste disposal program

Terms and Conditions

The undersigned applicant promises to pay to Western Drug Distribution Limited (“WDDC”) the principal sum (“Principal Sum”) of \$1,000.00 together with the interest as set out below. Subject to the Articles and By-laws of WDDC, the Principal Sum and all interest thereon shall be paid to WDDC by using the patronage allocations earned by the undersigned. *The undersigned acknowledges that if during any fiscal year the value of the patronage allocations for the undersigned is less than One Hundred (\$100.00) Dollars, such patronage allocations will not be credited towards the payment of the Principal Sum and interest.*

The undersigned hereby authorize WDDC to apply patronage allocations earned by the undersigned to pay for the Principal Sum and Interest.

The undersigned hereby irrevocably assigns all patronage allocations earned by the undersigned to WDDC until the Principal Sum and interest is paid in full.

If the undersigned applicant ceases to be a member of WDDC in good standing, then WDDC reserves the right without notice to cancel and revoke the undersigned’s common share, and all payments made by the undersigned to WDDC to date pursuant to this Promissory Note and all patronage allocations that may have been payable to the undersigned will become the property of and be retained by WDDC.

The undersigned hereby waives presentment for payment, notice of dishonor, protest and notice of protest.

I, _____ hereby wish to apply for the payment program set forth above and agree to the terms and conditions outlined in this letter.

Principle Sum \$1,000.00
Interest Rate 5.25% (calculated per year on remaining balance as of WDDC Fiscal Year End – June 30)

Signature

Date

If you choose to purchase a share via a Promissory Note, please include this signed form with your application for membership.



**OPTION C – payment plan
PROMISSORY NOTE TO ACQUIRE A SHARE IN
WESTERN DRUG DISTRIBUTION CENTER LIMITED**

The intent of this note is to enable you to enjoy all the benefits membership brings without the initial \$1,000.00 investment outlay. This note will be used to borrow from Western Drug Distribution Center Limited the sufficient funds necessary to purchase one common share. Upon approval of your application for membership, you will have immediate access to the following shareholder privileges:

- 1 vote per common share
- Annual dividends based on your purchases
- Value Pack Pet food pricing
- Affinity programs
- Case lot discount program
- Waste disposal program

Terms and Conditions

The undersigned applicant promises to pay to Western Drug Distribution Limited (“WDDC”) the principal sum (“Principal Sum”) of \$1,000.00 together with the interest as set out below. The Principal Sum and all interest thereon shall be paid to WDDC in 24 equal installments, each in the amount set forth below and such installments will be added to the undersigned’s statement of account with WDDC over such 12 month period.

If the undersigned applicant defaults in either the repayment of the Principal Sum and interest or in the payment of its trade account with WDDC, then WDDC reserves the right without notice to cancel and revoke the undersigned’s common share, and all payments made by the undersigned to WDDC to date pursuant to this Promissory Note and all patronage allocations that may have been payable to the undersigned will become the property of and be retained by WDDC.

The undersigned hereby waive presentment for payment, notice of dishonor, protest and notice of protest.

I, _____ hereby wish to apply for the share loan and agree to
(Print Name Here)

the terms and conditions as outlined in this letter.

Principle Sum	\$1000.00
Interest Rate	5.25%
Total Amount	\$1052.50
Amount to be applied to each statement	\$ 43.86
(as at January 1, 2003)	

Signature _____

Date _____

If you choose to purchase a share via Promissory Note, please include this signed form with your application for membership.



PRE-AUTHORIZED DEBIT PARTICIPANT AUTHORIZATION

PAYEE WESTERN DRUG DISTRIBUTION CENTER LIMITED 17611-109 A. Ave. EDMONTON, ALBERTA T5S 2W4 PHONE (780) 413-2508 FAX (780) 413-2530 TOLL FREE FAX 1-800-329-9332	ACCOUNT HOLDER	
	COMPANY NAME:	MEMBER NUMBER:
	STREET ADDRESS	CITY / PROV
	POSTAL CODE	PHONE # FAX #

DETAILS OF THE ACCOUNT TO WHICH PAYMENTS ARE TO BE WITHDRAWN:		
BANK OR FINANCIAL INSTITUTION NAME	DIRECT PAYMENT ROUTING NUMBER	
ADDRESS OR BRANCH	INSTITUTION NUMBER	BRANCH TRANSIT NUMBER
CITY/PROV.	POSTAL CODE	ACCOUNT NUMBER

I/WE AS THE ACCOUNT HOLDER(S), AUTHORIZED THE PAYEE AND THE ABOVE-NOTED FINANCIAL INSTITUTION TO DEBIT MY/OUR ACCOUNT, AT THE ABOVE INDICATED BRANCH OF THE FINANCIAL INSTITUTION, UNDER TERMS AND CONDITIONS AGREED TO BY ME/US WITH THE PAYEE UNTIL SUCH TIME AS WRITTEN NOTICE TO THE CONTRARY IS GIVEN BY ME/US TO THE PAYEE.

THE BRANCH OF THE FINANCIAL INSTITUTION AT WHICH I/WE MAINTAIN THE ACCOUNT IS NOT REQUIRED TO VERIFY THAT THE PAYMENT(S) ARE DRAWN IN ACCORDANCE WITH THIS AUTHORIZATION.

A DEBIT, IN PAPER, ELECTRONIC OR OTHER FORM IN THE AMOUNT OF MY/OUR STATEMENT BALANCE GENERATED ON THE 1st AND THE 16th OF EVERY MONTH.

I/WE WILL NOTIFY THE PAYEE IN WRITING OF ANY CHANGES IN THE ACCOUNT INFORMATION OR TERMINATION OF THE AUTHORIZATION PRIOR TO THE NEXT DUE DATE OF THE PRE-AUTHORIZED DEBIT.

ITEMS CHARGED WILL BE REIMBURSED SUBJECT TO NOTIFICATION BY ME/US TO THE BRANCH OF ACCOUNT WITHIN 10 DAYS UNDER ANY OF THE FOLLOWING CONDITIONS:

- A) I/WE NEVER PROVIDED THE AUTHORIZATION TO THE PAYEE.
- B) THE PRE-AUTHORIZED DEBIT WAS NOT DRAWN IN ACCORDANCE WITH THIS AUTHORIZATION.
- C) MY/OUR AUTHORIZATION WAS REVOKED.
- D) THE DEBIT WAS POSTED TO THE WRONG ACCOUNT DUE TO INVALID/INCORRECT INFORMATION BY THE PAYEE.

I/WE UNDERSTAND THAT A WRITTEN DECLARATION TO THIS EFFECT MUST BE GIVEN TO MY/OUR FINANCIAL INSTITUTION.

I/WE ACKNOWLEDGE THAT DELIVERY OF THE AUTHORIZATION TO THE PAYEE CONSTITUTES DELIVERY BY ME/US TO THE ABOVE-NOTED FINANCIAL INSTITUTION.

SIGNATURE OF ACCOUNT HOLDER	DATE
SIGNATURE OF ACCOUNT HOLDER	DATE

PLEASE ATTACH A SAMPLE CHEQUE MARKED "VOID"



PERSONAL CREDIT INFORMATION

Please provide the following information so that we may obtain your credit history:

Name: _____

Home Address: _____

City: _____

Province: _____

Postal Code: _____

Phone Number: _____

Previous address if less than 1 year at present address:

Home Address: _____

City: _____

Province: _____

Postal Code: _____

Social Insurance
Number: _____

Date of Birth: _____

Signature: _____





CREDIT CARD PAYMENT AUTHORIZATION

Your Center accepts MASTERCARD® and VISA® as an alternative means of paying your statement balance.

The benefits to you by charging your purchases to your MASTERCARD®/VISA® will allow you to take advantage of the various AIRMILES or other incentive programs currently in place with your credit card company. In addition, you may have the ability to extend payment terms according to the various financial institutions' terms.

Please take a couple of moments to read the following agreement. If you wish to use your card for payment, please fill in and sign the bottom of this form as authorization and fax it back to your Center at 1-800-329-9332. At the present time, MASTERCARD® and VISA® are the only cards that your Center can accept as a form of payment.

- ◆ This form must be completed and filed at the WDDC office before we are authorized to charge your statement balance to your MASTERCARD®/VISA®.
- ◆ Presently MASTERCARD® charges you a rate of 1.92% and VISA® charges 1.82%.
- ◆ MASTERCARD®/VISA® purchases are eligible for WDDC's 1% prompt payment discount, providing that the account is kept current.
- ◆ **WDDC will automatically process your card 3 business days before the close of the next statement cycle. Please ensure you have an adequate credit limit to cover your purchases. (WDDC Statement cycles are the 15th and 30th of each month)**

If you have any questions please do not hesitate to call us at 780-413-2163 or 1-877-746-9332.

Date _____ Member Number _____

Clinic Name _____

Card Holder Name _____

Please check one:

- Yes, I would like to use my MASTERCARD®/VISA® to charge my WDDC invoices on my statement 3 business days before the end of the statement cycle.
- No, please keep my MASTERCARD®/VISA® on file for any future WDDC charges I request.

My VISA® # _____ / _____ / _____ Exp. ____ / ____

My MASTERCARD® # _____ / _____ / _____ Exp. ____ / ____

Signature _____

Date _____

I agree to the above terms and authorize WDDC to charge purchases to the above Card Number. I understand these rates/policies are subject to change based on rates charged and policies in effect by the merchant financial institutions. These may change with or without notice.

