Register as a stockist

Please allow 1 – 2 days to allow for verification

Business Details

Owner's Name ______________________________

Owner's Contact details ______________________________

Do you have any qualified healthcare personel working in the store? (Pharmacist, Homeopath, Dietician etc.)

Yes No

If yes, please attach qualifications of main health consultant when submitting this form.

Store Details

Store email ______________________________

Store contact number ______________________________

Store website______________________________

If other, please list ______________________________

Street Address

Street address (number & street) ______________________________

Suburb, City, Province______________________________

Postal Code ______________________________

Country ______________________________

Accounts department

Accounts contact person ______________________________

Accounts contact number______________________________

Accounts email ______________________________

Have you consulted with one of our representatives?

Yes [ ] No [ ] No but I would like to [ ]

If yes, please provide details ______________________________

Would you like to receive email marketing from us? Yes [ ] No [ ]