PHARMAHOUSE

Claim Form

Request to Return Goods to Pharmahouse

Your Invoice Address	
Date	PO No.

Your Delivery Address
Telephone:
Claim Number:

PLEASE COMPLETE THE FORM BELOW USING THE FOLLOWING REASON CODES:

A	Short Delivered
B	Over Delivered
C	Received Damaged
D	Received Out of Date/Short Dated

E	Wrong Product
F	Pricing Error
G	Product Recall
H	Other

No.	Reason	Quantity	Description
1.			
2.			
3.			
4.			

No.	Goods to be Returned	Replacement Stock Required (tick)	Credit Required (tick)	Other (please state)
1.				
2.				
3.				
4.				

I ____________________(inset name), the Responsible Person of _______________ (insert company name), certify that the goods have been stored at a licenced wholesaler site and in accordance with GDP regulations).

_________________ Signed. Date: _____________

	Name	Date
Claim Highlighted By:		
RP Approved? Y/N (RP to sign)		