HEALTHWEALTH INTERNATIONAL CORPORATION
REQUEST FOR ISSUING CERTIFICATE

DATE: _____

NAME: _____

DEALER NO.: _____

DATE OF REGISTRATION: _____

REQUESTED MONTH/ YEAR: _____

PURPOSE OF CERTIFICATE (Pls specify:)

_____

Certificate as Dealer:

☐ **With Amount**

☐ **Without Amount**

(Note: Please attached photocopy of Valid ID)

REQUESTED BY: _____

Dealer's Signature over Printed Name

RECEIVED BY: _____

Customer Relations Staff

DETAILS:

DON'T FILL UP. FOR IT VERIFICATION ONLY.

_____

VERIFIED BY: