

Medical Supplies Depot

CREDIT APPLICATION

APPLICANT _____ PRIMARY CONTACT _____

ADDRESS _____ TELEPHONE (____) _____

CITY _____ STATE _____ ZIP _____ FAX (____) _____

E-MAIL _____

FORM OF BUSINESS: Corporation Sole Proprietorship LLC/Partnership Other _____ TAXABLE STATUS: Taxable Non-taxable *Attach tax-exempt certificate.*

CREDIT LINE REQUESTED \$ _____ *Financial information may be required if more the \$500 open credit is requested.*

PRINCIPALS/OWNERS _____

PRIMARY TRADE REFERENCES	
Name _____ Street _____ City _____ State _____ Zip _____ Phone _____ Fax _____ Account # _____ A/R CONTACT _____	Name _____ Street _____ City _____ State _____ Zip _____ Phone _____ Fax _____ Account # _____ A/R CONTACT _____
Name _____ Street _____ City _____ State _____ Zip _____ Phone _____ Fax _____ Account # _____ A/R CONTACT _____	Name _____ Street _____ City _____ State _____ Zip _____ Phone _____ Fax _____ Account # _____ A/R CONTACT _____

The undersigned authorizes inquiry as to credit information and acknowledges that credit privileges, if granted, may be withdrawn at any time. The undersigned's signature constitutes acceptance of and agreement to the Terms and conditions of Sale found on the reverse side hereof.

AUTHORIZED SIGNATURE

DATE

PRINTED NAME

TITLE/POSITION

GUARANTIES	
The undersigned parties, being so authorized by the Applicant seeking credit, hereby extend their personal guaranties of repayment to Medical Supplies Depot of any and all debts, including both principal and interest and including fees and charges accrued thereon, incurred by Applicant as a result of Applicant's being granted credit through this Credit Application.	
Date _____ Guarantor Signature _____ Name _____ Home Address _____ City _____ State _____ Zip _____ Home Phone (____) _____ D.O.B. _____ S.S.N. _____	Date _____ Guarantor Signature _____ Name _____ Home Address _____ City _____ State _____ Zip _____ Home Phone (____) _____ D.O.B. _____ S.S.N. _____