

APPLICATION FOR CREDIT



INTERNAL USE ONLY
Acct #: _____
Credit: \$ _____

2865 Coleman Street, North Las Vegas, Nevada 89032
Tel: 702-939-5900 Fax: 702-939-5907

NEW ACCOUNT INFORMATION:

Please type or print, being sure to complete ALL of the following information in order to expedite the approval of your request for credit.

Bill to:

NAME: _____
ADDRESS: _____
CITY, STATE, ZIP: _____
PHONE: _____
FAX: _____
Email 1 _____
YEAR BUSINESS STARTED: _____

Ship to:

NAME: _____
ADDRESS: _____
CITY, STATE, ZIP: _____
PHONE: _____
FAX: _____
Email 2 _____
FISCAL YEAR STARTS: _____

OWNERSHIP INFORMATION:

FORM OF BUSINESS: ___ PROPRIETORSHIP ___ PARTNERSHIP ___ CORPORATION (STATE: _____)

PROPRIETOR, PARTNERS, OR CORPORATE OFFICERS (Please provide an alternate address where we may reach you)

- 1) Name: _____
Title: _____ Address: _____
SS # or FEIN #: _____ City, St. Zip: _____
- 2) Name: _____
Title: _____ Address: _____
SS # or FEIN #: _____ City, St. Zip: _____
- 3) Name: _____
Title: _____ Address: _____
SS # or FEIN #: _____ City, St. Zip: _____

Sales Tax Resale Certificate number (Mandatory): _____ State: _____
Copy MUST be provided.

DUNS number: _____ SAN number: _____

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REFERENCES:

Vendor references only. Provide at least three references or check appropriate trade references on the back of this form. Use another page if necessary.

1) Firm name: _____ Address: _____

Account number: _____ City, State, Zip: _____

2) Firm name: _____ Address: _____

Account number: _____ City, State, Zip: _____

3) Firm name: _____ Address: _____

Account number: _____ City, State, Zip: _____

4) Firm name: _____ Address: _____

Account number: _____ City, State, Zip: _____

BANK INFORMATION:

Bank: _____ Account number _____

Address: _____ City, State: _____

Zip Code: _____ Type(s) of account: _____

Please note your preference: Prepaid Net 30 - Other terms _____.

Credit limit requested: _____

Credit Card type (for prepaid orders):

Card Number: _____

Expiration Date: _____

**** Enclose a financial statement for a more accurate credit appraisal.**

**** Orders can be sent Prepaid until your account is set up and credit established.**

YOU WILL BE NOTIFIED WHEN YOUR ACCOUNT IS OPEN.

I AUTHORIZE THE ABOVE LISTED CREDIT REFERENCES, INCLUDING MY BANK, TO RELEASE INFORMATION TO MED-HEALTH MEDICAL SUPPLIES, LLC. AS AN AUTHORIZED REPRESENTATIVE, I ACCEPT THE SELLER'S TERMS AND AS SUCH AND SUBJECT TO A SERVICE CHARGE OF 1.5% PER MONTH (18% PER ANNUM) ON BALANCES EXCEEDING TERMS. FURTHERMORE, I UNDERSTAND THAT MY ORDERS WILL NOT BE SHIPPED IF MY ACCOUNT IS PAST DUE. I HAVE RECEIVED A COPY OF MED-HEALTH MEDICAL SUPPLIES, LLC TRADE POLICIES AND AGREE TO ABIDE BY THEM AND AGREE TO PAY COSTS AND EXPENSES, INCLUDING ATTORNEYS' FEES, IF MED-HEALTH MEDICAL SUPPLIES, LLC IS FORCED TO CONSIGN THIS ACCOUNT FOR COLLECTIONS.

X _____

(Signature of Proprietor, Partner, or Corporate Officer and Title)

Date