

BUSINESS CONTACT INFORMATION			
Name			
Company Name:			
Phone:		E-mail:	
Registered company address:			
City		State:	Zip Code:
Date business commenced:			
Sole proprietorship:	Partnership:	Corporation:	Other:
Federal ID#:		Resale#:	
BILLING INFORMATION			
Primary billing address:			
City		State:	Zip Code:
How long at current address?			
Telephone:		E-mail:	
SHIPPING INFORMATION			
Primary shipping address:			
City		State:	Zip Code:
How long at current address?			
Telephone:		E-mail:	
ACCOUNTS PAYABLE CONTACT			
Name			
Phone		E-mail:	
BUSINESS/TRADE REFERENCES			
Company Name:			
Address:			
City:		State:	Zip Code:
Phone:		E-mail:	
Type of account:			
Company Name:			
Address:			
City:		State:	Zip Code:
Phone:		E-mail:	
Type of account:			
Company Name:			
Address:			
City:		State:	Zip Code:
Phone:		E-mail:	
Type of account:			
BANK REFERENCE			
Bank Name:			
Bank Address:			
City:		State:	Zip Code:
Bank Contact:	Phone:	E-mail:	
AGREEMENT			
<ol style="list-style-type: none"> All invoices are to be paid 30 days from the date of the invoice, unless otherwise noted. Claims arising from invoices must be made within seven working days. By submitting this application, you authorize DirectMed Parts & Service, LLC to make inquiries into the banking and business/trade references that you have supplied. 			
SIGNATURE			
Signature:		Print Name:	
Title:		Date:	