Account Application

Application must be completed and signed, with order attached, to initiate processing.

NAME ______________________ Parent or Subsidiary of ______________________

Do you or parent have an existing acct. #: ☐ Yes ☐ No If yes, please provide acct. #: ______________________

Headquarters Location ______________________ Are you a distributor: ☐ Yes ☐ No

Billing Address ______________________

City ______________________ County ______________________ State ________ Zip ______________________

Shipping Address ______________________

City ______________________ County ______________________ State ________ Zip ______________________

Telephone Number w/Area Code: (   ) ______________________ Fax Number w/Area Code: (   ) ______________________

Amount of Credit Line Requested: $ ______________________ Date Business Started: ______________________

Are Vouchers Required for Payment: ☐ Yes ☐ No If yes, please submit with orders. D & B #: ______________________

ARE YOU TAX EXEMPT: ☐ Yes ☐ No **If yes, you must provide Bound Tree Medical with a copy of your tax exemption certificate to avoid being charged taxes.**

SHIPPING: Complete Only ☐ Partial Shipment Okay ☐ Are PO's Required ☐ Yes ☐ No

The following persons are authorized to purchase from this account:

1. Name ______________________ Title ______________________
2. Name ______________________ Title ______________________
3. Name ______________________ Title ______________________

NAME AND TELEPHONE OF PERSON RESPONSIBLE FOR ACCOUNTS PAYABLE:

Name ______________ Phone # ______________ Fax # ______________ Email: ______________

REFERENCES:

Bank ______________________ Bank Contact Name ______________________

Address ______________________ City ______________ State ________ Zip ______________

Phone (   ) ______________________ ACCOUNT NUMBER (REQUIRED) ______________________

AUTHORIZATION TO RELEASE BANK INFORMATION

This is my authorization to the Bank to release information to Bound Tree Medical, for the purpose of evaluating our application for credit.

Authorized Bank Signature X ______________________ Date ______________

REFERENCES (MAJOR SUPPLIERS)

1. Major Supplier Name ______________________ Account# ______________________
   Telephone Number w/Area Code (   ) ______________________ Fax Number (   ) ______________________
   Address ______________________ City ______________________ State ________ Zip ________
2. Major Supplier Name ______________________ Account# ______________________
   Telephone Number w/Area Code (   ) ______________________ Fax Number (   ) ______________________
   Address ______________________ City ______________________ State ________ Zip ________
3. Major Supplier Name ______________________ Account# ______________________
   Telephone Number w/Area Code (   ) ______________________ Fax Number (   ) ______________________
   Address ______________________ City ______________________ State ________ Zip ________

This information is warranted to be true and is given for the purpose of obtaining credit from Bound Tree Medical. I (we) agree to pay all bills for purchases net 30 days from the date of invoice. Should legal action be instituted to enforce payment of any outstanding balance, I (we) agree to pay all costs of suit and reasonable attorney's fees.

Signature X ______________________

Print Name & Title ______________________ Date ______________

Please mail the completed form to: Bound Tree Medical
PO Box 8023
Dublin, OH 43016-2023

or Fax to: (866) 284-7504

Payment Remittance Address: Bound Tree Medical, LLC
23537 Network Place
Chicago, IL 60673-1235