



# State and Municipal 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. #: \_\_\_\_\_  
**Billing Address** \_\_\_\_\_  
 City \_\_\_\_\_ County \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
**Shipping Address** \_\_\_\_\_  
 City \_\_\_\_\_ County \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Telephone Number w/Area Code: \_\_\_\_\_  
 Fax Number w/Area Code: \_\_\_\_\_  
 Are Vouchers Required for Payment:  Yes  No If yes, please submit with orders.  
 Amount of Credit Line Requested: \_\_\_\_\_  
 FEIN #: \_\_\_\_\_ 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 Number \_\_\_\_\_  
 Fax Number \_\_\_\_\_ Email \_\_\_\_\_

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