



CONFIDENTIAL CREDIT APPLICATION

Date Account Name Federal Tax ID #

Address City State Zip

Sole Proprietorship Partnership Corporation D&B Rating #

Billing Address City State Zip

Main Phone Main Fax

Affiliates Name ProMed Sales Rep

Address City State Zip

Accounts Payable Contact Name Title Email Daytime Phone

Administrative Contact Name Title Email Daytime Phone

OWNERS

Name % Stake Social Security # Phone

Address City State Zip

Name % Stake Social Security # Phone

Address City State Zip

Name % Stake Social Security # Phone

Address City State Zip



OFFICERS

_____ Name	_____ Title	_____ Social Security #	_____ Phone
_____ Address	_____ City	_____ State	_____ Zip

_____ Name	_____ Title	_____ Social Security #	_____ Phone
_____ Address	_____ City	_____ State	_____ Zip

CREDIT REFERENCES

_____ Name	_____ Account #	_____ Contact	_____ Phone	_____ Fax
_____ Address	_____ City	_____ State	_____ Zip	

_____ Name	_____ Account #	_____ Contact	_____ Phone	_____ Fax
_____ Address	_____ City	_____ State	_____ Zip	

_____ Name	_____ Account #	_____ Contact	_____ Phone	_____ Fax
_____ Address	_____ City	_____ State	_____ Zip	

BANK REFERENCES

_____ Name	_____ Account #	_____ Contact	_____ Phone	_____ Fax
_____ Address	_____ City	_____ State	_____ Zip	

_____ Name	_____ Account #	_____ Contact	_____ Phone	_____ Fax
_____ Address	_____ City	_____ State	_____ Zip	



You are hereby authorized to release credit information about our account standing, credit line and payment history to Professional Medical, Inc. to be used explicitly for the establishment of an account and credit line. This information is to be kept in strictest of confidence.

Signature _____ Print Name _____ Title _____

Tax Exempt? Yes No *If Yes, please attach a copy of Certificate of Sales Exemption

Reseller Certificate _____ OR Sales Tax # _____

Credit Line Requested _____ Projected Monthly Purchases _____

A service charge of 1.5% per/mo will be assessed on all past due balance. I hereby request open account terms. In consideration of the extension of credit with your company, I guarantee full and complete payment of account and certify that all information on this application is correct and accurate. Customer agrees to pay all cost of collection and attorney's fees incurred by Professional Medical in the enforcement of this Agreement or in the collection of any amounts due and owing Professional Medical from Customer.

Customer agrees that if exception is taken to any invoice, either as to the amount of such invoice or to the products shipped in connection with such invoice, Customer shall notify Professional Medical of the exception, in writing, within thirty (30) days of the date of the invoice. Customer hereby waives any and all defenses or claims which it may have in connection with any invoices or products for which such written notice is not timely given to Professional Medical.

Customer hereby consents to the jurisdiction of any state or federal court in Will County, Illinois, to hear and decide any suit or action brought to enforce the terms of this agreement or to collect any amounts due and owing Professional Medical from Customer. Customer, at Professional Medical's option waives trial by jury, any objection based on the doctrine of forum non conveniens, and any objection to venue in any action instituted hereunder or to collect any amounts due and owing Professional Medical. Customer agrees that the books and records of Professional Medical showing the account between Professional Medical and Customer shall be admissible in evidence, shall be binding upon Customer for the purpose of establishing the evidence therein set forth, and shall constitute prima facie proof thereof.

INFORMATION COMPLETED BY

Facility Representative _____ Title _____ Phone _____

Signature _____ Date _____

FAX COMPLETED CREDIT APPLICATION TO 866-726-7416

*All information herein is the express property of Professional Medical, Inc. All disclosed information is for the use of Professional Medical, Inc. employees ONLY. This document is digitally signed and tracked. All exceptions MUST be approved by Professional Medical, Inc. Management. If you have received this document in error, please immediately contact the Professional Medical, Inc. legal department at 800-648-5190.