

APPLICATION FOR CREDIT



2875 Coleman Street, North Las Vegas, Nevada 89032
Tel: 702-949-6399 Fax: 702-631-5733

INTERNAL USE ONLY

SAP Acct #: _____

Credit Line: \$ _____

Acct. Rep.: _____

NEW ACCOUNT INFORMATION:

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

Bill to:

Name: _____

Address: _____

City, State, Zip: _____

Phone: _____

Fax: _____

Email: _____

Physician Medical License #: _____

Pharmacy License #: _____

Ship to:

Name: _____

Address: _____

City, State, Zip: _____

Phone: _____

Fax: _____

DEA Registration #: _____

BOP Controlled Substance License # _____

Year business started: _____ 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: _____

SS# or FEIN#: _____

Address: _____

City, State, Zip: _____

2) Name: _____

Title: _____

SS# or FEIN#: _____

Address: _____

City, State, Zip: _____

3) Name: _____

Title: _____

SS# or FEIN#: _____

Address: _____

City, State, Zip: _____

Sales Tax Resale Certificate Number (Mandatory): _____ State: _____

Copy MUST be provided

DUNS Number: _____

SAN Number: _____

REFERENCES:

Vendor references only. Please provide at least three references. 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: _____

Type(s) of Account: _____

Please note your preference: Prepaid Net 30 Other Terms _____

Credit Limit Requested: _____ Annual Rx Sales: _____

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 CREDIT IS OPEN

I authorize the above listed credit references, including my bank, to release information to Med-Health Pharmaceutical Products, 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 Pharmaceutical Products, LLC trade policies and agree to abide by them and agree to pay costs and expenses, including attorney's fees, if Med-Health Pharmaceutical Products, LLC is forced to consign this account for collections.

X

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

Date