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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | | | |  | | | | | | | | | | | |
| **APPLICATION**  **FOR**  **COMMERCIAL CREDIT** | | | | Sapphire House, Albion Mills, Albion Road, Greengates,  Bradford, BD10 9TQ  Tel: 01274 623270  Fax: 01274 620961  Email: Enquiries@cmilogistics.co.uk | | | | | | | | | | | |
| **Full Name of Applicant:**  **(and trading name if different)** | | | |  | | | | | | | | | | | |
| **Trading Address:** | | | |  | | | | | | | | | | | |
| **Telephone Number:** | | | |  | | | | | | | | **Fax Number:** | | |  |
| **Registered Address: (if different from above)** | | | |  | | | | | | | | | | | |
| **Business Type:** | | | | **Limited Company** | | | | | | | | **Sole Trader** | | | **Partnership** |
| *Tick as appropriate* | | | |  | | | | | | | |  | | |  |
| **VAT Registration Number:** | | | | | |  | | | | | | | | | |
| **If Limited Company, Reg. No.:** | | | | | |  | | | | | | | | | |
| **If Partnership selected, please give full names (not initials) and home addresses of all partners.**  **(use a separate sheet if necessary)** | | | | 1 | |  | | | | | | | | | |
| 2 | |  | | | | | | | | | |
| **References:**  *Company Name, addresses, telephone numbers and contact details of two principal suppliers.* | | | | 1 | |  | | | | | | | | | |
| Value of Monthly Purchases £ | | | | | | |  | | |
| 2 | |  | | | | | | | | | |
| Value of Monthly Purchases £ | | | | | | |  | | |
|  | | | | | | | | | | | | | | | |
| **Company Bank Details** | | | | | | | | | | | | | | | |
| **Bank Name** |  | | | | | | | | | | **Branch** | | |  | |
| **Sort Code** |  |  |  | |  |  |  |  |  | | **Account No.** | | |  | |
| *Maximum Anticipated Monthly Credit Required from us:* | | | | | | | | | | |  | | | | |
| *Name of person responsible for payment:* | | | | | | | | | | |  | | | | |
| *Email address of person responsible for payment:* | | | | | | | | | | |  | | | | |
|  | | | | | | | | | | |  | | | | |
| **DECLARATION BY APPLICANT SEEKING CREDIT** | | | | | | | | | | | | | | | |
| *All new accounts are subject to 30 days from date of invoice monitored over a period of three months.* | | | | | | | | | | | | | | | |
| *Signed:* |  | | | | | | | | | | | | | | |
| *Name (Please Print)* |  | | | | | | | | | | | | | | |
| *Date:* |  | | | | | | | | | *Position:* | | | |  | |

*Please return this form via post, email or fax.*