Capital Medical Resources LLC

# NEW ACCOUNT & CREDIT APPLICATION

| | | | |
|---|---|---|---|
| BUSINESS INFORMATION (TO BE COMPLETED FOR ALL NEW ACCOUNTS.) TIP: TAB THROUGH TO COMPLETE ALL FIELDS.) | | | |
| Company name: | | | |
| Phone: | Fax: | E-mail: | |
| Billing address: | | | |
| City: | | State: | ZIP Code: |
| Shipping address: | | | County: |
| City: | | State: | ZIP Code: |
| DUNS: | Fed Tax ID: | W-9<br>(Please Attach) | Tax Exempt? Attach Cert.<br>Yes ☐ No ☐ |
| BUSINESS CONTACT AND SHIPPING INFORMATION (TO BE COMPLETED FOR ALL NEW ACCOUNTS) | | | |
| Main Buyer's Contact Name & Title: | | | |
| Telephone: | Fax: | E-mail: | |
| Accounts Payable Contact Name & Title: | | | |
| Telephone: | Fax: | E-mail for Invoices: | |
| Preferred Method of Shipping: | | i.e., FedEx, UPS, Ground, Next Day. (Default Best Way / Ground) | |
| Shipping Account Number: | | (Provide Receiver/3rd Party Acct.) Insure >$100? Yes ☐ No ☐ | |
| *****IF YOU ARE APPLYING FOR NET 30 TERMS PLEASE COMPLETE ALL ITEMS BELOW***** | | | |
| BUSINESS CREDIT INFORMATION | | | |
| Bank name: | | | |
| Bank address: | | Phone: | |
| City: | | State: | ZIP Code: |
| Type of account (provide one): | Account number (below) | | Contact: |
| Savings | | | |
| Checking | | | |
| BUSINESS/TRADE REFERENCES | | | |
| Company name: | | | |
| Address: | | | |
| City: | | State: | ZIP Code: |
| Phone: | Fax: | E-mail: | Contact: |
| Company name: | | | |
| Address: | | | |
| City: | | State: | ZIP Code: |
| Phone: | Fax: | E-mail: | Contact: |
| Company name: | | | |
| Address: | | | |
| City: | | State: | ZIP Code: |
| Phone: | Fax: | E-mail: | Contact: |

## AGREEMENT

1. Terms Net 30. All invoices are to be paid 30 days from the date of the invoice.
2. Freight is pre-paid and added to invoice unless buyers account # is provided.
3. Claims must be made within seven working days of receipt of goods.
4. By submitting this application, you authorize Capital Medical Resources LLC to make inquiries into the banking and business/trade references that you have supplied.

## e-SIGNATURES

| | |
|---|---|
| Name / e-Signature | Title:<br><br>Date: |

**Please return via email to leeann.purtell@capitalmedicalresources.com, or by fax to 614.467.3923.**

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