Credit Application

DDP MEDICAL SUPPLY

Tel: 800-437-4455 Fax: 800-571-9444

11800 28th St. N., St. Petersburg, FL 33716

Legal Corporate Name

Check all that apply: Document # Exp Date

D.B.A. Name

NPI Number

Billing Street Address

DEA Certification Number

CLIA Certificate Number

City State Zip

Check if shipping address is same as billing address

Shipping Street Address

Telephone Number

City State Zip

Fax Number

Accounts Payable Contact (First & Last Name) | Accounts Payable E-Mail | Accounts Payable Phone #

Purchasing Contact (First & Last Name) | Purchasing E-Mail | Purchasing Phone #

Officers, Partners or Owners of the Business

First & Last Name, Title | % Owned | First & Last Name, Title | % Owned

First & Last Name, Title | % Owned | First & Last Name, Title | % Owned

Type of Business

☐ Sole Proprietorship Social Security Number _____

☐ Partnership ☐ Limited Partnership

☐ LLC ☐ (S) Corp ☐ (C) Corp State Incorporated | Year Incorporated | FEIN

☐ Other _____ Explain _____

Sales Taxable? ☐**Yes** ☐**No** If **No**, please include a copy of your exemption or resale certificate with this credit application.

NABP Accredited Drug Distributor

Initials

Company Name (as listed on first page): _____

Please indicate what type of facility you are:

☐Clinic ☐Homecare/DME Provider ☐Retail Pharmacy ☐Physician

☐Distributor ☐Long-Term Care ☐Surgery Center ☐Other: _____

Drug License Types:

- ☐ Not Applicable
- ☐ Physician
- ☐ Pharmacy
- ☐ Wholesale Distributor
- ☐ Advanced Practice Registered Nurse

☐ *I am a physician, pharmacy, or wholesale distributor and planning on purchasing prescription drugs.* (Attach copy of license)

☐ *I am a physician, pharmacy, or wholesale distributor and planning on purchasing controlled substances.* (Attach copy of DEA Controlled Substance Registration Certificate)

Business References

Please provide at least three (3) medical supply or medical manufacturer references.

☐ Prepaid Customer Not Seeking Credit _____ Initials

Name | Phone #

Street Address | Fax #

City | State | Zip | Account #

Name | Phone #

Street Address | Fax #

City | State | Zip | Account #

Name | Phone #

Street Address | Fax #

City | State | Zip | Account #

Bank Reference

Name | Account #

Street Address | Phone #

City | State | Zip | Fax #

NABP Accredited Drug Distributor

Initials

Company Name (as listed on first page): _____

I, AN AUTHORIZED REPRESENTATIVE, warrant the information herein to be accurate and true, and grant permission to DDP Medical Supply to contact the references as well as to conduct commercial and consumer credit checks. We agree to pay within terms established by DDP Medical Supply and understand that a late fee of 1.5% per month, or the current highest percentage allowed by law, may be imposed upon the accrued, unpaid balance of any invoice not paid within the established terms. If the account is placed for collection or with an attorney for collection, whether a lawsuit is filed or otherwise, or if the services of an attorney are required to protect the interests of DDP Medical Supply, we agree to pay all costs and reasonable attorney's fees, and further consent and agree that jurisdiction and venue shall be exclusively in the state courts of Pinellas County, Florida.

We understand and agree that all returns must have prior authorization.
NO CREDIT WILL BE ISSUED FOR UNAUTHORIZED RETURNS.

WE HEREBY GRANT PERMISSION to DDP Medical Supply and its subsidiaries to send advertising promotional materials to email addresses and fax numbers listed herein, or additionally provided by a representative of our company. This permission operates as consent under 47 USC § 227 of the Telephone Consumer Protection Act. Applicant agrees that in exchange for the extension of credit or for the right to purchase goods from DDP or its affiliated companies, in the event it changes any fax number that it provides to DDP or its affiliates, it shall immediately advise DDP or its affiliates in writing that Applicant is no longer the subscriber of the fax number(s) it provided to DDP or its affiliates. Applicant acknowledges that a breach of this obligation could subject it to damages.

This agreement shall be binding on our representatives, successors, and assigns.

Signature – First and Last Name	Date
Print Name – First and Last Name	Print Title

Personal Guaranty*

*REQUIRES SIGNATURE OF OWNER OR CORPORATE OFFICER

To induce DDP to sell goods to the Applicant, the undersigned agrees to the above terms which are herein incorporated and personally guarantees and agrees to pay, when due, and upon demand, the full amount of any indebtedness including attorney fees and costs incurred for collections, owed to DDP by the applicant with such sales.

Guarantor Signature First and Last Name	Date	Printed Name of Guarantor First and Last Name	Title	Last 4 Digits of SS#
Guarantor Signature First and Last Name	Date	Printed Name of Guarantor First and Last Name	Title	Last 4 Digits of SS#