



# ACCURATE MEDICAL SURGICAL Phone: (216)260-1511

<b>CREDIT APPLICATION</b>							
For the purpose of procuring and establishing credit with Accurate Medical Surgical herein known as "AMS" and to enable the undersigned to utilize AMS's goods and/or services on a credit basis.							
<b>Name:</b>	<b>DBA/Trade Name:</b>						
<b>Shipping Address:</b>							
	<i>Street</i>						
	<i>City</i>			<i>State</i>	<i>Zip Code</i>		
<b>Billing Address:</b>							
	<i>Street</i>						
	<i>City</i>			<i>State</i>	<i>Zip Code</i>		
<b>Telephone:</b>				<b>Email:</b>			
<b>Please circle one:</b> Individual    Partnership    Corporation    Other:							
<b>If Incorporated:</b>	Date:			State:			<b>Federal ID #</b>
<b>Dun &amp; Bradstreet #:</b>				<b>D&amp;B Name:</b>			
<b>Drug License Type (please circle one if applicable):</b> Wholesaler    Pharmacy    Other:							
* If applicable please submit any licensing related to your class of trade							
Credit Limit requested:				Estimated Monthly Purchases:			
Is Customer in operation?    Yes    No				If "No" when are operations anticipated?			
Is there any reason to believe Customer will become insolvent in the next 12 months?    Yes    No							
Is there any reason to believe Customer will be sold in the next 12 months?    Yes    No							
If "yes" to the above question, to whom may the Customer be sold?							
<b>Are there currently any lawsuits, liens, or judgments filed against applicant or it's business, and/or has applicant ever filed for bankruptcy?</b> Yes    No							
<b>If yes, please provide details:</b>							
<b>DETAILS OF SALE</b>							
<b>Goods being considered to be purchased on credit:</b>							
Will goods purchased be resold?    Yes    No        *If yes, please attach copy of resale certification.							
Please note if resale certificate is not provided AMS will be required to charge sales tax at time of sale.							
<b>Person responsible for payment of invoices:</b>							
				<b>Email:</b>			
<b>Telephone:</b>							
<b>Preferred method for invoicing purposes:</b> e-mail    fax    hard copy							



# ACCURATE MEDICAL SURGICAL Phone: (216)260-1511

<b>**PLEASE COMPLETE A SEPARATE CREDIT APPLICATION FOR THIS CORPORATE NAME**</b>					
<b>PARENT COMPANY:</b>					
<b>Name:</b>					
<b>Address:</b>					
		<i>Street</i>			
		<i>City</i>	<i>State</i>	<i>Zip Code</i>	
If L.P. or individual, quantify percentage of ownership:					
<b>PRINCIPALS, OFFICERS, PARTNERS OR OWNERS:</b>					
<b>1.</b>	<b>Name:</b>				
	<b>Address:</b>				
			<i>Street</i>		
			<i>City</i>	<i>State</i>	<i>Zip Code</i>
	<b>Telephone:</b>		<b>Email:</b>		
<b>2.</b>	<b>Name:</b>				
	<b>Address:</b>				
			<i>Street</i>		
			<i>City</i>	<i>State</i>	<i>Zip Code</i>
	<b>Telephone:</b>		<b>Email:</b>		
Has the Principal(s) listed previously had credit with any other AMS entities under another company name? Yes No					
		If yes, please list the name of the company (s):			
Are any of the Principal(s) involved with any other companies within the same line of business? Yes No					
		If yes, please list the name of the company (s):			
Will a corporate name other than the Customers be used on contracts, invoices, or any other paperwork? Yes No					
		If yes, please list the name:			
		What is the address?			
<b>BANK AND FINANCIAL REFERENCES:</b>					
<b>Name:</b>					
<b>Address:</b>					
		<i>Street</i>			
		<i>City</i>	<i>State</i>	<i>Zip Code</i>	
<b>Telephone:</b>		<b>Account #:</b>			



# ACCURATE MEDICAL SURGICAL Phone: (216)260-1511

<b>TRADE REFERENCES:</b>			
<b>1.</b>	<b>Company Name:</b>	<b>Contact:</b>	
	<b>Telephone:</b>	<b>Email:</b>	
<b>2.</b>	<b>Company Name:</b>	<b>Contact:</b>	
	<b>Telephone:</b>	<b>Email:</b>	
<b>3.</b>	<b>Company Name:</b>	<b>Contact:</b>	
	<b>Telephone:</b>	<b>Email:</b>	
Terms of payment are 1/10 Net 30 days from invoice date. In the event the account must be placed for collection, it will be the debtor's responsibility to pay all collection fees as well as legal fees incurred. Customer grants AMS consent to access their credit report.			
<b>AMS reserves the right to charge interest equal to 1.5 % per annum for all invoice balances paid beyond terms.</b>			
<b>SIGNATORIES:</b>			
Customer hereby warrants that the foregoing representations are true and correct. AMS is hereby authorized to obtain such information as it may require concerning the statements contained in this application and from the references listed herein. Said references are hereby authorized and directed to release such information to AMS upon receipt of a copy of this Credit Application. It is hereby agreed that this Application shall remain AMS's property whether or not credit is granted.			
<b>The undersigned hereby certifies that all statements in this Application are true and complete and are made for the purpose of obtaining credit.</b>			
SIGNATURE OF OFFICER/OWNER:			
TITLE:			DATED:
RETURN APPLICATION TO:	Accurate Medical Surgical 4595 Van Epps Road Brooklyn Heights, OH 44131  Phone: (216) 260-1511 Email: <a href="mailto:accountsetup@accuratemedicalsurgical.com">accountsetup@accuratemedicalsurgical.com</a>		