

BUSINESS CONTACT INFORMATION			
Name			
Company Name:			
Phone:		E-mail:	
Registered company address:			
City		State:	Zip Code:
Date business commenced:			
Sole proprietorship:	Partnership:	Corporation:	Other:
Federal ID#:		Resale#:	
BILLING INFORMATION			
Primary billing address:			
City		State:	Zip Code:
How long at current address?			
Telephone:		E-mail:	
SHIPPING INFORMATION			
Primary shipping address:			
City		State:	Zip Code:
How long at current address?			
Telephone:		E-mail:	
ACCOUNTS PAYABLE CONTACT			
Name			
Phone		E-mail:	
BUSINESS/TRADE REFERENCES			
Company Name:			
Address:			
City:		State:	Zip Code:
Phone:		E-mail:	
Type of account:			
Company Name:			
Address:			
City:		State:	Zip Code:
Phone:		E-mail:	
Type of account:			
Company Name:			
Address:			
City:		State:	Zip Code:
Phone:		E-mail:	
Type of account:			
BANK REFERENCE			
Bank Name:			
Bank Address:			
City:		State:	Zip Code:
Bank Contact:	Phone:	E-mail:	
AGREEMENT			
<p>1. All invoices are to be paid 30 days from the date of the invoice, unless otherwise noted.</p> <p>2. Claims arising from invoices must be made within seven working days.</p> <p>3. By submitting this application, you authorize DirectMed Parts & Service, LLC to make inquiries into the banking and business/trade references that you have supplied.</p>			
SIGNATURE			
Signature:		Print Name:	
Title:		Date:	