

Est. 1984

P.O. Box 207 • 127 Kingsley Rd. Ripley, MS 38663 800-638-0489 • Fax 800-837-8572 www.med-pro.com

CREDIT APPLICATION

Company Name:				
Address (Billing):				
City, State, Zip:				
Address (Shipping):				
City, State, Zip:**For multiple shipping destinations , plea	ase attach a separa	ate sheet.		
Phone: ()	Fax: ()_		Em	ail:
Purchasing Agent	Accounts Payable Contact			
() Corporation, Date Incorporated:			Tax ID #:	
	Tax ID #:			
	Tax ID #:			
<u>PRI</u>	NCIPAL OFFIC	CERS AN	D/OR PARTNERS	
1. Name	Т	Γitle		Tel
Address				
2. Name				Tel
Address			SSN	
*Please note that social security numbers are checks and this information is kept strictly c		luately che	ck your credit. We use l	Equifax services for our credit
enecks and this information is kept strictly e		REFERE	ENCES	
Name	1	Acct#	Co	ntact
Address				muct
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Phone	Fax		E-Mail	
	BANK	REFERE	ENCE	
Bank	Rranch	า		
Contact				
Phone	Fax			

The preceding information is for the purpose of obtaining credit and is warranted to be true. I/We hereby authorize Medical Products, Inc. to investigate all references and customary credit information sources including consumer credit reporting agencies regarding my/our credit and financial responsibility for the purpose of obtaining credit and for periodic review for the purpose of maintaining the credit relationship. In the event of default and if this account is turned over to an agency and/or an attorney for collection, the undersigned agrees to pay all reasonable attorney fees, and/or costs of collection. Principal 1 Date Principal 2 Date **Individual Personal Guarantee** ____, for and in consideration your residing at extending credit at my request to _ (hereafter referred to as the "Company"), of which I _(title), hereby personally guarantee to you the payment of any obligation of the Company. I hereby agree to bind myself to pay to you on demand any sum, which may become due to you by the Company whenever the Company shall fail to pay the same. I understand that this guarantee shall be a continuing and irrevocable guarantee and indemnity of such indebtedness of the Company. Signature Print Name Date

Please fax the completed application along with your resale certificate, sales tax exemption license, tax ID, and pharmacy license if applicable to our Credit Department @ 800-837-8572.