NEXT DAY MEDICAL

8870 Greenwood Place, Suite C
Savage, MD 20763
Phone (240) 294-1919 Fax (240) 294-1920

Credit Application

Company Name: Year Est.
Address:
City, State, Zip
Contact: Title:
Type of Business: Credit Limit Request:
Phone: Fax: Email:

Ownership Corporation:___ Partnership:___ Proprietorship:___ Other:___
Date of Incorporation ____/____/____
Sales Tax ID Fed Tax ID:
Tax Exempt #:
List Principals/Company Officers:
Name: Address:
Name: Address:
Name: Address:

Bank/Finance References
Bank Name: Phone #: Fax:
Address: Acct. Rep.:
City: State: Zip: Acct #:

Trade References (Minimum of Four)

Name:		Name:	
Contact:		Contact:	
City:	State:	City:	State:
Phone #:	Fax:	Phone#:	Fax:
Acct. #:		Acct. #	
Name:		Name:	
Contact:		Contact:	
City:	State:	City:	State:
Phone #:	Fax:	Phone #	Fax:
Acct. #:		Acct. #	

The undersigned confirms that the above information is true and accurate and hereby authorizes Next Day Medical, to obtain credit information from references listed above, or a commercial credit agency. If extended credit with Next Day Medical, the applicant promises to pay all purchases in accordance with terms. If at anytime the above business cannot meet its financial obligations with Next Day Medical, the undersigned agress to personally guarantee payments for all invoices. In the event the obligation has not been met to Next Day Medical, the undersigned will be responsible for the following costs: legal cost, collection cost (not to exceed 40%), interest at a rate of 1-1/2% per month (18%) per year, and any other fees incurred. A faxed copy of this document will serve as an original.

___________________________________ ____/____/____
Signature Date

____
Type or Print Name