Streamline Medequip, LLC

CREDIT APPLICATION

ACCOUNT INFORMATION			
Facility Name:			
Phone:	Fax:	Email:	
Facility Address:			
City:		State:	Zip:

FACILITY CONTACT INFORMATION			
Primary Facility Contact Name/Title:			
Phone:	Fax:	Email:	
Facility Accounts Payable Contact:			
Phone:	Fax:	Email:	
Email for Invoices:			

CORPORATE INFORMATION			
Owner Name:			☐ Individual ☐ Corporation
Phone:	Fax:	Email:	
Facility Address:			
City:		State:	Zip:
Corporate Primary Contact Name/Title:			
Phone:	Fax:	Email:	
Corporate Accounts Payable Contact:			
Phone:	Fax:	Email:	

CREDIT INFORMATION			
Bank Name:			
Bank Address:			
City:		State:	Zip:
Account#:	Contact:		PH:

TRADE REFERENCES			
Company Name:			
Address:			
City:		State:	Zip:
Phone:	Fax:	Email:	
Company Name:			
Address:			
City:		State:	Zip:
Phone:	Fax:	Email:	

AGREEMENT

1. All invoices are to be paid within 30 days of the date of invoice.
2. Claims arising from invoices must be made within 15 working days.
3. By submitting this application, you authorize inquiries into the banking and business references provided above.

SIGNATURE

Signature:		Date:
Name:	Title:	

EMAIL TO: johngilbert@streamlinemedequip.com 346-445-4017