completemedical supplies,inc.

12,000 Popular & Hard to Find Products

100 Route 59, Suite 103A, Suffern, New York USA 10901
Phone: 1-845-533-5073 Fax: 1-845-533-5092
Toll Free: 1-800-242-2674 www.completemedical.com

Credit Application

Processing of this application can only begin if this form is returned with all 8 sections completed.

GENERAL INFORMATION - PART 1

Business Name____

Owner__________________________ Contact____________________

Title__________________________ Phone______________________

Fax____________________ Cell____________________ E-mail____________________

Bill To Address:____
Street *City* *State* *Zip*

Ship To Address:____
Street *City* *State* *Zip*

Type of Business__________________ Federal Tax Identification Number ____________________
(Please include a copy of your FED ID Certificate)

How did you hear about Complete Medical Supplies, Inc.?____________________

BANK REFERENCES - PART 2

Bank Name:____

Branch Location:____

Phone:____

Fax:__________________________ Contact_____________________

Business Checking Account #________________________________

Business Savings Account #_________________________________

TRADE REFERENCES - PART 3

You must provide a minimum of three references

	Company Name	Account No.	Phone No.	Fax No.
1.				
2.				
3.				
4.				

Internet Download

PHARMACY SECTION - PART 4

Please indicate if your business contains a pharmacy: Yes / No (Circle One)_______________
If Yes, Please list ALL of your Drug Wholesalers: ______________________________________

SELLER'S REGISTRATION CERTIFICATE - PART 5

Taxing Jurisdiction	Exemption Certificate Number
_______________	_________________________
(Issued By State Of)	(You must include a copy of Your Sales Tax Certificate)

I hereby certify that I hold a valid Seller's Registration Certificate in each of the taxing jurisdictions indicated above and for which I have indicated a certificate number, and that I am engaged in the business of wholesaling, retailing, manufacturing, and / or leasing (renting).

The tangible personal property I shall purchase from Complete Medical Supplies, Inc.
_____ will be resold by me in the form of tangible property (or)
_____ will become an ingredient or component part of tangible personal property for later sale by me

I further certify that if any property so purchased tax free is used or consumed by my firm as to make it subject to a Sales or Use Tax our firm will pay tax due directly to the proper taxing authority, when state law so provides, or inform Complete Medical Supplies, Inc. for added tax billing. If the buyer purchases tax free for a special reason other than a Seller's Registration Certificate, the buyer should send Complete Medical Supplies, Inc. that special certificate or statement.

This certificate shall be a part of each order we may hereafter grant to you, unless otherwise specified, and shall be valid until cancelled in writing or revoked by the city or state. I declare under penalties or perjury that this certificate has been examined by me and to the best of my knowledge believe it true and correct and made in good faith. I recognize that misuse of the certificate may be punishable by fine and imprisonment under applicable state laws.

I have read and agree to the above (Please initial)_________________________

AGREEMENT SIGNATURE - PART 6

The above information is submitted for the purpose of obtaining credit and is warranted to be correct. I hereby authorize the release of credit information from any credit bureau, investigative source or bank for the purpose of establishing a line of credit. I agree to meet net 30 day terms if credit is extended. All order are subject to acceptance. I also do hereby agree that in the event of default in payment of any amount due or that if this account is placed in collection or litigation action, I will pay any additional charges equal to the cost of collection, including legal fees and interest charges. I also hereby give permission for the above mentioned bank (Part 2) to provide any and all credit information to Complete Medical Supplies, Inc.

By________________________________ **Date**___________________

Print Name________________________ **Title**____________________

This Credit Application can not be processed until Parts 7 & 8 have been completed.

When completed, please Fax Pages 1, 2 & 3 to 1-845-533-5092

CREDIT CARD USE / AUTHORIZATION - PART 7

_____ **Initial here if you would like ALL order to be charged to your credit card.**
(By signing this form, I authorize Complete Medical Supplies, Inc. to charge my credit card for an amount equal to any order(s) placed by my authorized agent(s) or me.)

By signing this section, should Complete Medical Supplies, Inc. agree to accept my company check and offer our company open account terms, I agree to allow my credit card to be charged for any bounced check(s) plus a $30.00 returned check fee. In addition, if I do not pay my invoices within a reasonable time period, I agree to allow Complete Medical Supplies, Inc. to charge the credit card below for those open invoices. In both of the above cases, I will not dispute the charges based on this agreement.

Signature (Owner of Card)____

Print Name Exactly as it Appears on Card______________________________

Credit Card Number____ **Exp Date**_______

(Check One) Visa_______ **Mastercard**_____ **American Express**_____

3 Digit Card Code Number on Back of Mastercard or Visa_______

4 Digit Card Code Number on Front of American Express________

(Check One) Corporate Card______ **Personal Card**_______

Address where bill is received____

____

City___________________________ **State**______________________ **Zip**____________________

OPENING ORDER - PART 8

(A Minimum $50.00 opening order must accompany this credit application. Once your account has been established, there is NO MINIMUM ORDER).

Bill To:
(Use Credit Application Bill To)

PO #________________

Ship To:
____
____
____
____

Qty	Item	Description	Price	Extension

Special Instructions:____