Business Contact Information

Title		Date business commenced	
Company name		☐ Sole proprietorship	
Phone | Fax		☐ Partnership	
E-mail		☐ Corporation	
Registered company address City, State ZIP Code		☐ Other	
Title		Date business commenced	
Company name		☐ Sole proprietorship	
Phone | Fax		☐ Partnership	
E-mail		☐ Corporation	
Registered company address City, State ZIP Code		☐ Other	

Shipping Information

DBA or Business Trade Name		Shipping contact person	
Estimated Monthly Purchases		Ship to Address City, State ZIP Code	
Primary Phone		Secondary Phone	
Fax		Additional Contact	
E-mail		Special Shipping Requirements	

Business/Trade References

Company name		Phone	
Address		Fax	
City, State ZIP Code		E-mail	
Type of account		Other	
Company name		Phone	
Address		Fax	
City, State ZIP Code		E-mail	
Type of account		Other	
Company name		Phone	
Address		Fax	
City, State ZIP Code		E-mail	
Type of account	☐Savings ☐ Checking ☐ Other	Other	
☐Copy of State Pharmacy License	☐Copy of Resale/Tax Exemption	DEA #	
☐Copy of Medical License	☐Copy of DEA Registration	HIN #	

PLEASE FILL FORM AND SUBMIT TO [illegible]

Customer Set-Up & Authorization for ACH

Bank Name		Bank Address	
City, State Zip Code		Bank Transit ABA #	
Bank Account #		Bank Phone Number	
ACH Preference (Check One)	☐Direct Debit ☐ Online Payment	Additional Contact	
Statement Delivery Preference	☐Email ☐ Fax ☐ Mail	Invoice Delivery Preference	☐Email ☐ Fax ☐ Mail
Statement Frequency Requested		Invoice Frequency Requested	

Agreement

1. All invoices are to be paid 30 days from the date of the invoice.
2. Claims arising from invoices must be made within seven working days.
3. By submitting this application, you authorize American Medical Depot to make inquiries into the banking and business/trade references that you have supplied.
4. Customer agrees to abide by, and acknowledge having received and reviewed American Medical Depot's returns Policy.

   Price billed is the current price in effect at the time of item shipment

Signatures

Authorized Signature		Authorized Signature	
Name and Title		Name and Title	
Date		Date	

PLEASE FILL FORM AND SUBMIT TO [illegible]