CONFIDENTIAL CREDIT APPLICATION

Date | Account Name | Federal Tax ID #

Address | City | State | Zip

Sole Proprietorship ☐ Partnership ☐ Corporation ☐ | D&B Rating #

Billing Address | City | State | Zip

Main Phone | Main Fax

Affiliates Name | ProMed Sales Rep

Address | City | State | Zip

Accounts Payable Contact Name | Title | Email | Daytime Phone

Administrative Contact Name | Title | Email | Daytime Phone

OWNERS

Name | % Stake | Social Security # | Phone

Address | City | State | Zip

Name | % Stake | Social Security # | Phone

Address | City | State | Zip

Name | % Stake | Social Security # | Phone

Address | City | State | Zip

We Make Improving Care Easier!®
1917 Garnet Ct. New Lenox, IL 60451
800.648.5190 fax 866.726.7416
promedsupply.com

OFFICERS

Name	Title	Social Security #		Phone
Address		City	State	Zip
Name	Title	Social Security #		Phone
Address		City	State	Zip

CREDIT REFERENCES

Name	Account #	Contact	Phone	Fax
Address		City	State	Zip
Name	Account #	Contact	Phone	Fax
Address		City	State	Zip
Name	Account #	Contact	Phone	Fax
Address		City	State	Zip

BANK REFERENCES

Name	Account #	Contact	Phone	Fax
Address		City	State	Zip
Name	Account #	Contact	Phone	Fax
Address		City	State	Zip

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You are hereby authorized to release credit information about our account standing, credit line and payment history to Professional Medical, Inc. to be used explicitly for the establishment of an account and credit line. This information is to be kept in strictest of confidence.

Signature | Print Name | Title

Tax Exempt? Yes ☐ No ☐ *If Yes, please attach a copy of Certificate of Sales Exemption

Reseller Certificate **OR** Sales Tax #

Credit Line Requested | Projected Monthly Purchases

A service charge of 1.5% per/mo will be assessed on all past due balance. I hereby request open account terms. In consideration of the extension of credit with your company, I guarantee full and complete payment of account and certify that all information on this application is correct and accurate. Customer agrees to pay all cost of collection and attorney's fees incurred by Professional Medical in the enforcement of this Agreement or in the collection of any amounts due and owing Professional Medical from Customer.

Customer agrees that if exception is taken to any invoice, either as to the amount of such invoice or to the products shipped in connection with such invoice, Customer shall notify Professional Medical of the exception, in writing, within thirty (30) days of the date of the invoice. Customer herby waives any and all defenses or claims which it may have in connection with any invoices or products for which such written notice is not timely given to Professional Medical.

Customer hereby consents to the jurisdiction of any state or federal court in Will County, Illinois, to hear and decide any suit or action brought to enforce the terms of this agreement or to collect any amounts due and owing Professional Medical from Customer. Customer, at Professional Medical's option waives trial by jury, any objection based on the doctrine of forum non conveniens, and any objection to venue in any action instituted hereunder or to collect any amounts due and owing Professional Medical. Customer agrees that the books and records of Professional Medical showing the account between Professional Medical and Customer shall be admissible in evidence, shall be binding upon Customer for the purpose of establishing the evidence therein set forth, and shall constitute prima facie proof thereof.

INFORMATION COMPLETED BY

Facility Representative | Title | Phone

Signature | Date

FAX COMPLETED CREDIT APPLICATION TO 815-846-4994.

**All information herein is the express property of Professional Medical, Inc. All disclosed information is for the use of Professional Medical, Inc. employees ONLY. This document is digitally signed and tracked. All exceptions MUST be approved by Professional Medical, Inc. Management. If you have received this document in error, please immediately contact the Professional Medical, Inc. legal department at 800-648-5190.*

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