



Account Application

Application must be completed and signed, with order attached, to initiate processing.

NAME _____ Parent or Subsidiary of _____
 Do you or parent have an existing acct. #: Yes No If yes, please provide acct. #: _____
 Headquarters Location _____ Are you a distributor: Yes No
Billing Address _____
 City _____ County _____ State _____ Zip _____
Shipping Address _____
 City _____ County _____ State _____ Zip _____
 Phone Number w/Area Code: () _____ Fax Number w/Area Code: () _____
 Amount of Credit Line Requested: \$ _____ Date Business Started: _____
 Are Vouchers Required for Payment: Yes No If yes, please submit with orders. D & B #: _____

STATE SALES TAX EXEMPT: Yes No If yes, you must provide Bound Tree Medical with a copy of your tax exemption certificate to avoid being charged taxes.
NAME AND TELEPHONE OF PERSON RESPONSIBLE FOR ACCOUNTS PAYABLE:
 Name _____ Phone # _____ Fax # _____ Email: _____

SHIPPING: Complete Only Partial Shipment Okay Are PO's Required Yes No
 The following persons are authorized to purchase from this account:
 1. Name _____ Title _____
 2. Name _____ Title _____
 3. Name _____ Title _____

REFERENCES (MAJOR SUPPLIERS)
 1. Major Supplier Name _____ Account# _____
 Phone Number w/Area Code () _____ Fax Number () _____ Email _____
 Address _____ City _____ State _____ Zip _____
 2. Major Supplier Name _____ Account# _____
 Phone Number w/Area Code () _____ Fax Number () _____ Email _____
 Address _____ City _____ State _____ Zip _____
 3. Major Supplier Name _____ Account# _____
 Phone Number w/Area Code () _____ Fax Number () _____ Email _____
 Address _____ City _____ State _____ Zip _____

This information is warranted to be true and is given for the purpose of obtaining credit from Bound Tree Medical. I (we) agree to pay all bills for purchases net 30 days from the date of invoice. Should legal action be instituted to enforce payment of any outstanding balance, I (we) agree to pay all costs of suit and reasonable attorney's fees.

Signature **X** _____
 Print Name & Title _____ Date _____

Please mail the completed form to: Bound Tree Medical
 PO Box 8023
 Dublin, OH 43016-2023
or Fax to: (866) 284-7504

Payment Remittance Address: Bound Tree Medical, LLC
 23537 Network Place
 Chicago, IL 60673-1235
TIN #: 31-1739487

For Internal Use Only

Approved By _____
 Date Approved _____ Terms _____ Limit _____



Dear Valued Customer:

In an attempt to enhance our efficiency and improve your customer experience, we are now offering you the ability to receive your invoices electronically. This green initiative will not only ensure you receive your invoices in a timely manner, but will help us to reduce excessive paper usage and reduce our carbon footprint.

To receive invoices via email or fax, please fill out the following information:

Customer Account Number: _____

Customer Name: _____

Email Address(es) (Up to 2): _____

Fax Number: _____

Requester Name: _____

Contact Phone Number: _____

Please scan, email or fax this information to the following email addresses:

<u>Company</u>	<u>Email address</u>	<u>Phone</u>	<u>Fax</u>
Bound Tree Medical	credit@boundtree.com	1-800-282-7904	1-866-284-7504

We encourage you to sign up for this opportunity and help us reduce our carbon footprint.

Kind Regards,

Your Bound Tree Credit and Collections Department