TO:..
PHONE: ....
FAX:...

Credit Application

Hospitals, Nursing Homes, Assisted Living and other Medical Facilities

BILLING INFORMATION

LEGAL NAME:	TRADE NAME/DBA:
BILLING ADDRESS:	PHONE:
	FAX:
CITY: STATE: ZIP:	EMAIL:

ACCOUNT INFORMATION

YEAR BUSINESS WAS ESTABLISHED:	FEDERAL TAX ID #:
	DUN & BRADSTREET #:
ANTICIPATED ANNUAL PURCHASES: $	CREDIT LINE REQUESTED:

IS THE ENTITY TAX EXEMPT? ☐ YES ☐ NO (IF YES, ATTACH COPY OF EXEMPTION CERTIFICATE)

CONTACT INFORMATION

CONTROLLER'S NAME:	PHONE:
ACCOUNTS PAYABLE CONTACT:	PHONE:
PURCHASING CONTACT:	PHONE:

OWNERSHIP INFORMATION

CHECK ONE: ☐ A) PUBLIC CORP. ☐ B) PRIVATE CORP. ☐ C) PARTNERSHIP ☐ D) PROPRIETOR ☐ E) NOT FOR PROFIT

If a or b, list names and address of Parent Corp. If c, d or e, list name(s), address(es) and social security numbers of Owner(s)

NAME:	NAME:
ADDRESS:	ADDRESS:
CITY: STATE: ZIP:	CITY: STATE: ZIP:
(If you need more room, please list information on additional sheet)	SSN:

1665 Corporate Road West, Lakewood, NJ 08701
www.avacaremedical.com

P: 1.877.813.7799
E: info@avacaremedical.com

BANK REFERENCE

BANK NAME:	ACCOUNT #:
ADDRESS:	PHONE:
CITY: STATE: ZIP:	FAX:

TRADE REFERENCE

NAME:	ACCOUNT #:
ADDRESS:	PHONE:
CITY: STATE: ZIP:	FAX:
NAME:	ACCOUNT #:
ADDRESS:	PHONE:
CITY: STATE: ZIP:	FAX:
NAME:	ACCOUNT #:
ADDRESS:	PHONE:
CITY: STATE: ZIP:	FAX:
NAME:	ACCOUNT #:
ADDRESS:	PHONE:
CITY: STATE: ZIP:	FAX:

The Applicant grants permission to Avacare Medical to contact commercial & consumer credit reporting agencies and any or all bank & trade references provided, together with any other references which may be provided by these references.

I hereby certify that, to the best of my knowledge and belief, the information stated above is true and correct. That I am duly authorized by the Applicant to submit this application and make agreements and representations contained herein in the name of and on behalf of the Applicant.

PRINT NAME: ______________________ TITLE: ______________________

SIGNATURE: ______________________ DATE: ______________________