New Account Application

Business Name ____________________
Business Address ____________________
City, State and Zip Code ____________________
Phone ____________________ **Fax** ____________________
Website ____________________

Purchasing Name and Title ____________________
Phone ____________________ **Email** ____________________

Ship-To Name and Title ____________________
Ship-To Address (if different) ____________________
City, State and Zip Code ____________________
Phone ____________________ **Email** ____________________

Accounts Payable Name and Title ____________________
Billing Address (if different) ____________________
City, State and Zip Code ____________________
Phone ____________________ **Email** ____________________
Buying Group Affiliation ____________________

Facility Type

Hospital ☐ **OP Surgery Center/ASC** ☐ **Private Practice** ☐ **Other** ____________________

Business Type

LLC ☐ **C-Corporation** ☐ **S-Corporation** ☐ **Partnership** ☐ **Sole-Proprietorship** ☐

Number of Years in Business __________ **State of Incorporation** ____________________
Federal Tax ID # ____________________ **DUNS #** ____________________
Certificate of Exemption # (Please attach a copy) ____________________
Has this business ever filed bankruptcy? **Yes** ☐ **No** ☐

Ownership: Please list name and percentage of business owned for all individual and/or entity owners.

If additional space is needed, please attach a complete list on a separate document.

____ ____

____ ____

____ ____

Bank Name ____

Branch Location ____

Type of Account(s) ____

Contact Name and Title ____

Phone ______________________________________ **Email** ______________________________________

Medical Trade References

1. Company Name ____

Contact Name and Title ____

Phone ____________________________________ **Email** ______________________________________

2. Company Name ____

Contact Name and Title ____

Phone ____________________________________ **Email** ______________________________________

3. Company Name ____

Contact Name and Title ____

Phone _____________________________________ **Email** ______________________________________

By signing below, Applicant certifies that the information provided in this application is true and correct. Applicant authorizes SafetyFix to contact all references provided in this application and authorizes all references to release any information to SafetyFix relative to the applicant. Payment terms are Net 30 days from invoice date, however, SafetyFix reserves the right to amend terms based on its review of Applicant's credit worthiness.

____

Applicant Signature

____

Applicant Printed Name

____

Title

____

Date