

# CREDIT APPLICATION

Failure to fill in all blanks may delay processing. Application must be signed by owner or duly authorized representative.

FAX COMPLETED APPLICATION TO 877-868-8406 or email to [customerservice@innomedinc.com](mailto:customerservice@innomedinc.com)

PLEASE COMPLETE THE FOLLOWING INFORMATION:

Firm Name:	Phone #		
Parent Corporation:	Fax #		
Purchasing Contact:	Email:		
Billing Address:			
City	State	Zip	Country
Accounts Payable Contact:		Accounts Payable Phone #	
Accounts Payable Email:			
Date Business Started:			

**U.S. TRADE REFERENCES**  
\*Companies with whom credit has been established

1. Name	Type of Business		
Address	City	State	Zip
Telephone ( )	FAX#	Payment Terms	Customer #
2. Name	Type of Business		
Address	City	State	Zip
Telephone ( )	FAX#	Payment Terms	Customer #
3. Name	Type of Business		
Address	City	State	Zip
Telephone ( )	FAX#	Payment Terms	Customer #

Expected monthly purchase amounts approximately: \$

In consideration of the extension of credit and establishment of a credit account, applicant acknowledges liability for payment of amounts due InnoMed Technologies for delivery of InnoMed Technologies' products. If InnoMed Technologies must take action to collect any balance owing, applicant agrees to pay all reasonable costs and expenses incurred in collection including, but not limited to, reasonable attorney's fees, court costs, and interest thereon at the then maximum legal rate. By signing this agreement, applicant acknowledges payment will be made according to quoted terms on invoice. All past due invoices are subject to interest of 1.5% per month charged on balances. Signature also authorizes the release of credit information concerning your company that InnoMed Technologies may reasonably require.

X Authorized Signature	Title	Date
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