



Anderson Medical Enterprises

817 Highway 50 • Milford, Ohio 45150 • 513-831-0507 • Fax 513-831-4051

APPLICATION FOR CREDIT

COMPANY NAME: _____ DATE: _____

BILLING ADDRESS: _____

TELEPHONE: _____ FAX: _____

FEDERAL TAX I.D. #: _____ SALES TAX #: _____

BUSINESS TYPE: Corporation Partnership Sole Proprietorship

YEAR ESTABLISHED: _____ STATE VENDOR'S LICENSE #: _____

OFFICERS:

NAME: _____
ADDRESS: _____

TELEPHONE: _____

NAME: _____
ADDRESS: _____

TELEPHONE: _____

TRADE REFERENCES:

NAME: _____
ADDRESS: _____

TELEPHONE: _____

NAME: _____
ADDRESS: _____

TELEPHONE: _____

FINANCIAL INSTITUTION:

NAME: _____ ACCT. NO.: _____
ADDRESS: _____

TELEPHONE: _____

I/We the undersigned certify that all the information on this form is correct and that we understand the terms of this agreement are as specified on the invoice. Late payments may be assessed a penalty of 1.5% per month or the highest legal allowable rate which may be in effect at the time of purchase. Failure to pay can result in account being placed in collection and all legal fees will be at expense of the undersigned.

SIGNED: _____ DATE: _____

SIGNED: _____ DATE: _____