OMNI MEDICAL SUPPLY

4153 Pioneer Drive
Walled Lake, MI 48390
omni@omnimedicalsupply.com

Phone : 1-800-860-OMNI
Local: 1-248-360-8000
Fax: 1-248-360-9375

APPLICATION FOR OPEN ACCOUNT

Legal Name: _____

Billing Address: _____

_____

Shipping Address: _____

_____

Contact Name: _____

Phone Number: _____ **Fax Number:** _____

Sales Tax Exempt #: _____ **DEA/Pharmacy License #**_____ _____
(Must Supply Copy of Above Certificates/Licenses)

Fed. I.D. # or Social Security #: _____

Date Established:_____

Type of Business: **Partnership** **Corporation** **Other:**_____

Owners and/or Officers:

Name	Title	Drivers License #
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Bank Reference: (Please complete in full)

Bank Name: _____**Branch Office:**_____

Contact Name:_____**Phone #:**_____

Fax#:_____**Loan #:**_____

Address:_____

Savings Account #:_____**Checking Account #:**_____

Trade References (a minimum of 3 references will be checked by OMNI MEDICAL SUPPLY, INC.)

Name:_____

Address:_____

Telephone #:_____ **Fax #:**_____

Account #:_____**Contact:**_____

Products purchased from this Vendor:_____

Name:_____

Address:_____

Telephone #:_____ **Fax #:**_____

Account #:_____**Contact:**_____

Products purchased from this Vendor:_____

Name:_____

Address:_____

Telephone #:_____ **Fax #:**_____

Account #:_____**Contact:**_____

Products purchased from this Vendor:_____

Name:_____

Address:_____

Telephone #:_____ **Fax #:**_____

Account #:_____**Contact:**_____

Products purchased from this Vendor:_____

Amount of Credit Requested:_____ **Preferred Method of Payment:**_____

Unless otherwise stated, payment on account must be made within terms from the date billed. All invoices are Net 30 days from date of invoice. A service charge of 1 _% per month will be assessed if the account is not paid within terms. In the event the amount due and owing is placed with an attorney for collection, the applicant and guarantors herein agree to pay costs of court and reasonable attorney's fees.

I, the undersigned, authorize OMNI MEDICAL SUPPLY, INC. to investigate the information herein provided. The undersigned, in consideration of the delivery of merchandise by OMNI MEDICAL SUPPLY, INC. to the above applicant, hereby unconditionally and personally agrees to assume any liability incurred by the above company and guarantees that payment will be made strictly according to the terms set forth. In the event of default, the guarantor agrees to pay interest, costs and fees of collection as stated herein.

Print Name_____ **Signature:**_____
Title:_____ **Date:** _____
Drivers License #:_____