



NEWMATIC MEDICAL

Credit Application

The questions asked herein are pertinent to making a sound credit decision; therefore, please complete ALL ITEMS, including fax numbers. Please fax back to (616) 871-7171. By signing below, you acknowledge that you have read and understand Newmatic Medical terms of sale that are provided with this application. Please note that Newmatic Medical terms for credit are Net 30 days. Thank you for your promptness.

Legal Name of Company _____

DBA (if different) _____

Telephone _____ Fax _____

Year Established _____ Duns # _____

Tax Status
<input type="checkbox"/> Tax Exempt (attach Certificate)
<input type="checkbox"/> Taxable

Physical Address:

Street _____

City _____ State _____ Zip _____

Billing Address (if different):

Street _____

City _____ State _____ Zip _____

Accounts Payable Contact:

Name _____ Phone # _____ Email _____

Does your facility require PO numbers? YES NO

Bank Reference:

Bank _____ Address/City/State/Zip _____

Contact Name _____ Telephone Number _____ Fax Number _____

Account Number _____ Routing Number _____

Trade References:

1. Vendor Name _____ Address/City/State/Zip _____

Account Number _____ Fax Number **(REQUIRED)** _____

2. Vendor Name _____ Address/City/State/Zip _____

Account Number _____ Fax Number **(REQUIRED)** _____

3. Vendor Name _____ Address/City/State/Zip _____

Account Number _____ Fax Number **(REQUIRED)** _____

All Information submitted herein is acknowledged to be true and accurate.

Signature _____ Date _____