MDP

MDP Credit Account Application Form

Company Information:

Billing Information:

Facility Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Main Phone: _____ Main Fax: _____

Tax ID: _____ Attention To: _____

Bank: _____ Account Number: _____

Routing Number: _____

Shipping Information: *(Fill out only if different than billing)

Facility Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Main Phone: _____ Main Fax: _____

Attention To: _____

Standard Payment Terms for Your Facility:

Net 30 days_____

Tax Exempt: (If YES, tax exemption documents must be attached) Yes: __ No: __
*This question only applies to CA customers only.

DUNS# (if applicable) _____ Years Established: _____

MDP Credit Account Application Form Continued:

Purchasing Contact Information:

First Name: _____ Last Name: _____

Department: _____

Phone: _____ Fax: _____

Other Persons Authorized To Purchase:

1)_____ 2)_____

Accounts Payable Contact Information:

Title: _____ Department: _____

First Name: _____ Last Name: _____

Phone: _____ Fax: _____

Payment Terms: (Please read carefully)
All invoices issued by Medical Device Purchase, LLC are payable Net 30 days from the date of the invoice for all accounts with an approved line of credit. In the event that an invoice becomes 15 days past due, Medical Device Purchase, LLC reserves the right to charge a late fee of 5% for the past due amount of any and all invoices. You will be notified before this occurs and you will receive a copy of the paid invoice once payment has been received. Please make all checks payable to Medical Device Purchase.

Agreement:
Applicant agrees that extension of credit by Medical Device Purchase, LLC shall be subject to and in consideration of the "Terms and Conditions" located at www.medicaldevicepurchase.com. Applicant understands that MDP will make its usual credit investigation and authorize applicant's bank to release information as requested by MDP. The undersigned agrees that all credit extended shall be deemed subject to the terms herein agreed to.

Authorized Signature: _____ Title: _____

Date: _____ Please *email this form to: sales@medicaldevicepurchase.com*