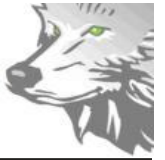


CREDIT APPLICATION



WWW.ALPHAMEDICALEQUIPMENT.NET

P.O. Box 88 Zimmerman, MN 5598
 Phone: (763)263-8576 Fax: (763)263-8577
 E-mail: alphamedicalequipment@izoom.net

Please Print or Type All Information on Order Form

CUSTOMER CONTACT INFORMATION			
DATE: _____	Number of years in business: _____		
COMPANY NAME: _____	PHONE: _____		
ADDRESS: _____	FAX #: _____		
CITY: _____	STATE: _____	ZIP: _____	
CONTACT: _____	TITLE: _____		
DIRECT PHONE: _____	E-MAIL: _____		

Name and Address of Individuals or Partners - Name/Title/Phone Number of Corporate Officers

Name of Persons to Contact Regarding Purchase Orders and Invoice Payments, Title, and Phone Number

Bank Reference	Bank Account Number, Contact, Title and Phone Number

Trade References: Company Name, Complete Address, Phone/Fax Number(s) & Account Number

I (We) agree to pay all bills for purchases net 30 days from the date of invoice and thereafter any invoice over 30 days a 1 1/2% per month will be added to unpaid balance after invoice.

The above information is herewith submitted for the purpose of opening an account and I do hereby certify this information to be true.

SIGNED: _____
 TITLE: _____
 DATE: _____

Account Application Notes: () Approved () Disapproved - Reasons _____