CREDIT APPLICATION

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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 _____

Alpha Medical Equipment, Inc. "An Innovative Leader for ALL Your Medical Supply Needs"