

## CREDIT APPLICATION FOR A BUSINESS ACCOUNT

**This Form is to be filled out by the entity responsible for payment.**

BUSINESS CONTACT INFORMATION	
Company name:	_____
Contact Person	_____
Phone:	_____ Fax: _____ E-mail: _____
Registered company address:	_____
City:	_____ State: _____ ZIP Code: _____
Date business commenced:	_____ Number of Employees _____
<b>Corporation</b> <input type="checkbox"/>	State of Incorporation _____ Federal Tax ID _____
<b>Three Chief Officers:</b>	
<b>Name</b>	Title _____
Address	_____
<b>Name</b>	Title _____
Address	_____
<b>Name</b>	Title _____
Address	_____
Name of Resident Agent	_____
Address of Resident Agent	_____
<b>Partnership</b> <input type="checkbox"/>	Names, addresses and Social Security Numbers of the partners
<b>Name</b>	Social Security _____
Address	_____
<b>Name</b>	Social Security _____
Address	_____
<b>Name</b>	Social Security _____
Address	_____
<b>Sole Proprietorship</b> <input type="checkbox"/>	Names, addresses and Social Security Numbers of the partners
<b>Name</b>	Social Security _____
Address	_____
<b>Name</b>	Social Security _____
Address	_____
<b>Name</b>	Social Security _____
Address	_____
Are you sales tax exempt? Yes <input type="checkbox"/> No <input type="checkbox"/> Resale # _____	
Have you ever had credit with TwinMed, LLC before? Yes <input type="checkbox"/> No <input type="checkbox"/>	
If yes, under what name?	
Purchase order required? Yes <input type="checkbox"/> No <input type="checkbox"/>	

BUSINESS AND CREDIT INFORMATION	
Bank name: _____	Contact Person _____
Bank address: _____	Phone: _____
City: _____	State: _____ ZIP Code: _____
Type of account    Savings <input type="checkbox"/> Checking <input type="checkbox"/> Other <input type="checkbox"/>	Account # _____
BUSINESS/TRADE REFERENCES	
<b>Company name:</b> _____	
Address: _____	
City: _____	State: _____ ZIP Code: _____
Phone: _____	Fax: _____ E-mail: _____
Type of account: _____	
<b>Company name:</b> _____	
Address: _____	
City: _____	State: _____ ZIP Code: _____
Phone: _____	Fax: _____ E-mail: _____
Type of account: _____	
<b>Company name:</b> _____	
Address: _____	
City: _____	State: _____ ZIP Code: _____
Phone: _____	Fax: _____ E-mail: _____
Type of account: _____	
AGREEMENT	
<p>I represent that the above information is true and is given to induce TwinMed, LLC to extend credit to the applicant. My company and I authorize TwinMed, LLC to make such credit investigation as it sees fit, including contacting the above trade references and banks and obtaining credit reports. My company and I authorize all trade references, banks and credit reporting agencies to disclose to TwinMed, LLC any and all information concerning the financial and credit history of my company and myself.</p> <p><b><u>I understand and agree that any disputes or conflicts between myself (and/or my business and/or my corporation) and TwinMed, LLC arising out of or relating to any transaction between the aforementioned parties shall be adjudicated under California law. Furthermore, any and all disputes or conflicts between myself (and/or my business and/or my corporation) and TwinMed, LLC shall be adjudicated in the appropriate California Superior Court, to whose jurisdiction I hereby submit to, unless all parties stipulate otherwise in writing.</u></b></p>	
<b>GENERAL TERMS AND CONDITIONS</b>	
<ol style="list-style-type: none"> <li>1. Statements are sent on the tenth day of each month.</li> <li>2. All bills become payable in full according to terms and if not paid according to terms are considered past due.</li> <li>3. A service charge of 1.5% per month will be added to all amounts bills if not paid according to terms.</li> <li>4. No additional credit will be extended to past due accounts unless satisfactory arrangements are made with our credit department.</li> </ol>	
SIGNATURES	
Authorized Signature _____	Title: _____
Print Name _____	Date: _____
<p>PLEASE COMPLETE AND FAX THESE 2 PAGES TO <b>(323) 319-1154</b> or SEND BY E-MAIL TO <b>salesprofiles@twinmed.com</b></p>	

## CUSTOMER INFORMATION & PURCHASE AUTHORIZATION

Proposed Start Date: \_\_\_\_\_ Salesperson: \_\_\_\_\_

Type (please select):

- New Customer (If multiple facilities, please attach a facility roster.)
- Update to Existing Customer
- New Addition to Current Chain (if so, Current Corp Association): \_\_\_\_\_

### Customer Information

Customer ID: _____	<input type="checkbox"/> Active	<input type="checkbox"/> Inactive
Total # of Beds: _____	Previous Supplier: _____	
Customer Name (if entity, specify LLC/LP/Inc.) _____		Contact Name / Attention To _____
Phone Number _____	Fax Number _____	E-mail Address _____
Street Address 1 _____		Street Address 2 _____
City and State _____		Zip Code _____
Requested Payment Terms: _____	Requested Credit Limit: _____	
Estimated Monthly Sales: _____		

### Management Contact & Billing

BILL TO:	<input type="checkbox"/> Owner	<input type="checkbox"/> Management/Corporate	<input type="checkbox"/> Facility	<input type="checkbox"/> Other: _____
STATEMENTS TO:	<input type="checkbox"/> Owner	<input type="checkbox"/> Management/Corporate	<input type="checkbox"/> Facility	<input type="checkbox"/> Other: _____
Bill To Name _____		Attention To _____		
Street Address 1 _____		Street Address 2 _____		
City and State _____		Zip Code _____		

### Shipping Information

Shipping Method _____	Distribution Center _____
Order Day _____	Delivery Day _____

**CUSTOMER INFORMATION & PURCHASE AUTHORIZATION**

**Pricing**

Class ID:  PPD  PPD Rate: \_\_\_\_\_  
 PPD (Subacute) Rate: \_\_\_\_\_  
 Non-PPD (please see attached pricing)  Payment Terms: \_\_\_\_\_

**Taxability Status**

Taxable  Non-Taxable: please check applicable certificate and attach copy  
 (1) Resale Certificate or  (2) Exemption Certificate

**Additional Questions and Information**

(1.) How will the customer order? (Please select)  
 (1a.)  EDI/DSSI (1b.)  TwinMed Website (1c.) Other: \_\_\_\_\_  
 (2.) Usages (Please select)  
 (2a.)  Attached (2b.) Other: \_\_\_\_\_  
 (3.) Electronic Billing (Required)  
 \_\_\_\_\_ (3a.) E-mail Address \_\_\_\_\_ (3b.) Fax Number

Customer Rep/Contact: \_\_\_\_\_ TwinMed Sales Rep: \_\_\_\_\_  
 Title: \_\_\_\_\_ TwinMed Approval: \_\_\_\_\_  
 Date: \_\_\_\_\_ Date: \_\_\_\_\_  
 Signature: \_\_\_\_\_

Customer's signature above signifies agreement that: (1) electronic signatures are equally as valid as original signatures on all order-related documents; (2) Customer's representative/contact has obtained all authorizations necessary to sign this instrument and place orders with TwinMed on behalf of Customer; and (3) Customer has actually received, and agrees to, all of TwinMed's terms of sale.

PLEASE COMPLETE AND FAX TO (323) 319-1154 or SEND BY E-MAIL TO [salesprofiles@twinmed.com](mailto:salesprofiles@twinmed.com)