TwinMed
MEDICAL SUPPLIES AND SERVICES

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 _____

Corporation ☐ State of Incorporation _____ Federal Tax ID _____

Three Chief Officers:

Name _____ Title _____

Address _____

Name Title _____

Address _____

Name _____ Title _____

Address _____

Name of Resident Agent _____

Address of Resident Agent _____

Partnership ☐ Names, addresses and Social Security Numbers of the partners

Name _____ Social Security _____

Address _____

Name _____ Social Security _____

Address _____

Name _____ Social Security _____

Address _____

Sole Proprietorship ☐ Names, addresses and Social Security Numbers of the partners

Name _____ Social Security _____

Address _____

Name _____ Social Security _____

Address _____

Name _____ Social Security

Address _____

Are you sales tax exempt? Yes ☐ No ☐ Resale # _____

Have you ever had credit with TwinMed, LLC before? Yes ☐ No ☐

If yes, under what name?

Purchase order required? Yes ☐ No ☐

11333 Greenstone Avenue | Santa Fe Springs, CA 90670
T: (323) 582-9900 | **Toll Free:** (877) TWIN-MED | **F:** (323) 319-1154
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BUSINESS AND CREDIT INFORMATION

Bank name: _____ Contact Person _____

Bank address: _____ Phone: _____

City: _____ State: _____ ZIP Code: _____

Type of account Savings ☐ Checking ☐ Other ☐ Account # _____

BUSINESS/TRADE REFERENCES

Company name: _____

Address: _____

City: _____ State: _____ ZIP Code: _____

Phone: _____ Fax: _____ E-mail: _____

Type of account: _____

Company name: _____

Address: _____

City: _____ State: _____ ZIP Code: _____

Phone: _____ Fax: _____ E-mail: _____

Type of account: _____

Company name: _____

Address: _____

City: _____ State: _____ ZIP Code: _____

Phone: _____ Fax: _____ E-mail: _____

Type of account: _____

AGREEMENT

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.

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.

GENERAL TERMS AND CONDITIONS

1. Statements are sent on the tenth day of each month.
2. All bills become payable in full according to terms and if not paid according to terms are considered past due.
3. A service charge of 1.5% per month will be added to all amounts bills if not paid according to terms.
4. No additional credit will be extended to past due accounts unless satisfactory arrangements are made with our credit department.

SIGNATURES

Authorized Signature _____ Title: _____

Print Name _____ Date: _____

PLEASE COMPLETE AND FAX THESE 2 PAGES TO **(323) 319-1154** or
SEND BY E-MAIL TO **DG-TM-Salesprofiles@twinmed.com**

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CUSTOMER INFORMATION & PURCHASE AUTHORIZATION

Effective 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: _____ ☐ Active ☐ 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: ☐ Owner ☐ Management/Corporate ☐ Facility ☐ Other: _____

STATEMENTS TO: ☐ Owner ☐ Management/Corporate ☐ Facility ☐ 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

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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

(4.) Rebates? (Required) ☐ Yes, customer will be serviced with Enteral/Nutritional products (TwinMed 006 items). Please complete information below. ☐ No

(4a.) Please provide Enteral / Nutritional vendors and Contract Number they are currently accessing:

_____

_____

Customer's signature below signifies that the facility acknowledges that TwinMed and its related parties, in capacity as Enteral Suppliers, are duly authorized to make and manage the enteral formulary decisions, including purchases, on behalf of facility.

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.

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