



MedCal Sales LLC 3350 Shelby Street, Suite 200 Ontario, CA 91764

CUSTOMER CREDIT APPLICATION FORM AND AGREEMENT

Note: In order to expedite the establishment of your new account with MedCal Sales LLC, (Medline) it is imperative that each section of this 3 page application be completed. Once completed and signed, you may choose to fax the application to (847) 837-2765.

Medline Sales Representative name _____

I. OWNERSHIP INFORMATION: Identify Corporate Entity, DBA, and/or principle owner(s). If there are multiple owners please attach a complete list including the names, address and the percentage of ownership.

Parent Company _____

Registered Company Name _____

Doing Business As _____

Who is financially responsible _____

Name of Owner(s) _____ Percent Owned _____

Home Address required for Sole Proprietor/Majority Shareholder, please complete below

Address _____ City _____ State _____ Zip _____

Phone _____ Fax Number _____

Title _____ SS# _____

State Tax Status: *For Tax Exempt, or Resale Status, a valid tax-exempt certificate for each ship to location is required. The below **MUST be completed before an account can be established.**

Tax Exempt/Not for Profit* _____ State Resale Number _____

Taxable/For Profit _____ **Federal ID Number** _____

Partnership _____ Corporation _____ Sole Proprietor _____ Publicly Traded _____ NBR of Employees _____

NBR of Beds _____ # of Facilities _____ Yrs in Business _____ Owned Property _____ Leased Property _____

Name of Lessor _____ Phone _____

Business Type (i.e..Hospital, Nursing Home, Institutional Dealer, Laundry, HME, etc.) _____

If Internet Business, please provide Website Address: _____

Annual Revenues \$ _____ **Requested Credit Limit \$** _____

(Please indicate the dollar volume of credit desired)

Are you part of a buying group? _____ Group Name _____

II. BILL TO CUSTOMER INFORMATION: complete if different from above (Invoices will be sent to this address)

Company Name _____

Address _____ City _____ St _____ Zip _____

Account Payable Phone _____ A/P Fax Number _____ A/P Contact Name: _____

III. SHIP TO INFORMATION: complete if different from BILL TO (designated shipping location)

Company Name _____

Address _____ City _____ St _____ Zip _____

Phone Number _____ Fax Number _____

NOTE : SHIP TO LOCATION(s) Applicant assumes financial responsibility for amounts due and owing to Medline. For multiple locations please attach a facility listing including the phone/fax information and the contact person's name. Complete if different from above. By signing this application the Applicant agrees to be responsible for all invoices and shipments to all of the facilities provided on a facility listing. Medline requires a separate credit application for each facility for which the Applicant is not responsible.

NOTE: PURCHASES OF PRESCRIPTION DRUGS REQUIREMENT

Purchases of prescription (Rx) drugs or medical devices from Medline, requires a copy of one of the following: Facility Pharmacy License; Institutional Pharmacy License; Wholesale Drug (or Device) Distributor License (both, if your state has separate licenses for drugs/devices); Physician Authorization Form (and a copy of the physician/medical directors license), Teaching Institution Letter (to certify RX products are used for teaching purpose), and other authorization as required by your state. Failure to submit the appropriate license may result in deletion of Rx items from order(s). Please note: address on the license must match the address of your ship-to location; please submit copies of all licenses if you have multiple facilities; if you have questions regarding this RX requirement, please contact our Medline Regulatory Affairs at 800.950.0128 ext. 2277.

IV. MANAGEMENT COMPANY / THIRD PARTY PAYER

Please Complete this section if another organization manages your payments.

Company Name(s) _____

Address _____ City _____ St _____ Zip _____

Phone _____ Contact Person _____

Yrs in Business _____ NBR of Managed Facilities _____ (Provide listing of managed entities)

Has the applicant had any prior history with Medline, or any of its owners or managers ever operated the same business under a different name?

If Yes, Company Name _____ Medline Acct Number _____

Address _____ City _____ St _____ Zip _____

Note: Attached Bank Release Authorization form must be completed or Terms will default to Cash In Advance

Terms: Invoices are due and payable within 30 days of invoice date. Proof of delivery must be requested within 30 days of shipment date on all normal delivery, express delivery must be requested within 10 days of shipment date. Service charges of 1 ½% per month, or as allowed by law will be assessed on all balances outstanding past specified credit terms. Any requests for extended payment terms must be approved by Medline corporate Credit Department. By signing this agreement you are authorizing Medline to send you advertisements via fax and or email. Customer consents to the jurisdiction of any state or federal court in Lake or Cook County, State of Illinois. Customer will be liable for reasonable costs and legal fees incurred by Medline Industries or any affiliate thereof to assist in the recovery of any receivables in default. The sales representative assigned to this Customer will negotiate the pricing and terms of this agreement for all orders and all such orders are placed pursuant to such negotiated terms. Any changes in these terms must be negotiated in writing with the assigned sales representative.

BY COMPLETING AND RETURNING THIS APPLICATION TO MEDLINE, THE APPLICANT REPRESENTS THAT ALL OF THE INFORMATION CONTAINED IN THIS APPLICATION IS TRUE AND CORRECT AND APPLICANT AGREES THAT IF ANY OF THE INFORMATION BECOMES OUTDATED OR IF APPLICANT LEARNS OF A POSSIBLE OR PENDING CHANGE IN OWNERSHIP OR MANAGEMENT OF IT OR ANY FACILITY, IT WILL IMMEDIATELY NOTIFY MEDLINE.

THE UNDERSIGNED OR APPLICANT IDENTIFIED AS PROPRIETOR, OWNER, AND OR MAJORITY SHAREHOLDER, AUTHORIZES MEDLINE INDUSTRIES, INC. TO VERIFY THIS INFORMATION BY OBTAINING DATA FROM A CREDIT REPORTING AGENCY. THE UNDERSIGNED ACKNOWLEDGES THAT HIS OR HER INDIVIDUAL CREDIT HISTORY MAY BE A FACTOR IN THE EVALUATION OF THE CREDIT HISTORY OF THE APPLICANT AND HEREBY CONSENTS AND AUTHORIZES THE USE OF A CONSUMER REPORT ON THE UNDERSIGNED BY MEDLINE INDUSTRIES, INC. FROM TIME TO TIME, AS MEDLINE INDUSTRIES, INC. MAY DEEM NECESSARY IN ITS CREDIT EVALUATION.

FOR APPLICANT:

By: _____ Signature: _____
(Print name)

Title: _____ Date: _____

Authorization to Release Credit Information

Company Name(s) as it appears on the Bank Account: _____

I _____ hereby authorize _____
(Must be authorized signer for account) (Name of Bank)

to release credit information to MedCal Sales LLC for the purpose of establishing credit on this _____ day of __, 200__.
Please, release credit information, on the account type(s) requested.

Authorized Signature Here: _____ Date: _____
(Person signing release form must be the **authorized** signer for the account(s).)

Bank Reference Information: Main Operating Account

Bank Name: _____ Phone: _____ Fax: _____

Address: _____ City _____ ST _____ Zip _____

Bank Contact Name: _____

_____ Checking Account # _____

_____ Savings Account # _____

_____ Line(s) of Credit Account # _____

_____ Other Account # _____

Reason for Inquiry: To establish an open credit line to purchase medical supplies. Medline will contact bank for below.

THIS SECTION RESERVED FOR BANK PERSONNEL TO COMPLETE:

Date Account(s) Opened: _____

Average Checking Account Balance: _____

Other Deposit Balance: _____

NSF Checks: Yes _____ No _____ Times Year-to-Date _____

Line of Credit Available: _____ Current Balance: _____

Term Loans: _____ High Credit: _____

Months Remaining: _____ Secured: _____ Unsecured: _____

Rating: _____

Name of Bank Personnel

Date

**All information received is strictly confidential and is for Medline's use only.
If only returning this 3rd page, please fax to 847 949 3155.**