Medline Industries One Medline Place Mundelein, IL 60060

CUSTOMER CREDIT APPLICATION FORM AND AGREEMENT

Note: In order to expedite the establishment of your new account with 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: ____________________ (Print name) Signature: ____________________

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 MEDLINE INDUSTRIES, INC. 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.
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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.