



MEDCAL SALES LLC, 3350 Shelby Street, Suite 200, Ontario, CA 91764

CUSTOMER CREDIT APPLICATION AND AGREEMENT

NOTE: To expedite the establishment of your new account with MedCal Sales LLC, (Medline), please complete in its entirety. Once completed and signed, please fax the application to (847) 837-2765.

Medline Sales Representative Name _____

I. OWNERSHIP INFORMATION: Identify Parent Company, controlling entity, or principle owner(s). If there are multiple owners please attach a complete list including the name, address and the percentage of ownership.

Parent Company _____ GLN Master Number _____

Address of Parent Company or Controlling Entity _____

Name of Principal Owner(s) / Stockholder(s) _____ Percent Owned _____

Annual Revenues \$ _____ **Requested Credit Limit \$** _____
(Please indicate the dollar volume of credit desired)

Home Address required for Sole Proprietor/Majority Shareholder:

Address _____ City _____ State _____ Zip _____

Phone _____ Title _____ Last 4 digits of Social Security # _____

II. SOLD TO: Registered Corporate Entity / DBA _____

Address _____ City _____ St _____ Zip _____

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

Company Name _____

Address _____ City _____ St _____ Zip _____

Accounts Payable Phone # _____ Accounts Payable Fax # _____

Accounts Payable Contact Person: _____ Email Address: _____

IV. SHIP TO INFORMATION: complete if a designated shipping location exists. For multiple locations please attach a facility listing including the phone/fax information and the contact person's name. By signing this application Applicant agrees to be financially responsible for amounts due and owing to Medline for all invoices and shipments to all of the facilities provided on a facility listing.

Business Name _____ GLN MASTER NUMBER _____

Address _____ City _____ St _____ Zip _____

Phone Number _____ Fax Number _____

What portion of your revenue is dependent on Government or State funding such as Medicare, Medicaid, etc. _____

Business Type (Hospital, Nursing Home, Surgery Center, Pharmacy, Laundry, HME Dealer, Internet, etc) _____

If Internet Business, please provide Website Address: _____

Corporation____ Partnership____ LLC____ Limited Partnership____ Proprietorship____ Publicly Traded____ Non Profit____

of Employees____ # of Beds____ # of Facilities____ Yrs in Business____ Owned Property____ Leased Property____

Are you part of a buying group? _____ Group Name / Membership # _____

Has Applicant(s), Parent or Business ever filed for Bankruptcy? ____NO ____YES (If yes, further information may be required)

Are you Accredited? If so, please provide Accrediting Agency and Accreditation #, or attach a copy of Accreditation Certificate.

Agency _____ **Accreditation #** _____

V. MANAGEMENT COMPANY / THIRD PARTY PAYER: Please Complete this section if another organization manages your payments.
(Provide listing of managed entities)

Company Name(s) _____

Address _____ City _____ St _____ Zip _____

Phone _____ Contact Person _____

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

If Yes, Company Name _____ Medline Acct Number _____

Address _____ City _____ St _____ Zip _____

***TAX EXEMPTION REQUIREMENTS:** *For Tax Exemption or Resale Status, a VALID tax exemption or resale certificate MUST be received before an account can be established. Each State has specific legal requirements regarding the exemption of sales and use tax. However, in ALL CASES, the name of the entity listed as the "SOLD TO" or selling party, must match the legal name of the entity the certificate was issued under by the state taxing authority.

Medline Industries & Subsidiaries has sales and use tax nexus in every state and is therefore required by law to charge sales tax unless a valid certificate is provided. In the majority of the states, if the "SOLD TO" is NOT registered for exemption within the "Ship To State", and Medline will be drop shipping on your behalf to your customers or affiliates located within that state, tax will be assessed. In a limited number of States, a home state resale certificate, along with a No Nexus form may satisfy the requirements for exemption. This documentation must be provided at the time the account is established and must be periodically updated as required to receive an exemption from sales tax.

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

Taxable/For Profit _____ Federal ID Number _____

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.

TERMS: Invoices are due and payable within 30 days of invoice date. All claims for defective or damaged goods must be made within four (4) days after receipt of goods. Failure to notify Medline shall constitute acceptance of work, waiver of defect, damage or shortage. Service charges of 1 ½% per month, or as allowed by law will be assessed on all balances outstanding past specified credit terms. 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 or any affiliate thereof to assist in the recovery of any invoices 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. Any requests for extended payment terms must be approved by Medline corporate Credit Department. Customer agrees product purchased from Medline will not be re-sold, distributed, exported or otherwise disposed of contrary to any relevant law or regulation, including but not limited to laws and regulations pertaining to embargoed countries and anti-boycott regulations.

BY COMPLETING AND RETURNING THIS APPLICATION TO MEDLINE, THE APPLICANT REPRESENTS THAT ALL OF THE INFORMATION CONTAINED IN THIS APPLICATION ARE 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 APPLICANT FURTHER AGREES THIS AGREEMENT SHALL BIND APPLICANT'S HEIRS, PERSONAL REPRESENTATIVES, SUCCESSORS AND ASSIGNS AND INURE TO THE BENEFIT OF MEDLINE.

THE UNDERSIGNED OR APPLICANT IDENTIFIED AS PROPRIETOR, OWNER, AND OR MAJORITY SHAREHOLDER, AUTHORIZES MEDLINE OR ITS SUBSIDIARIES 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 OR ITS SUBSIDIARIES FROM TIME TO TIME, AS MEDLINE OR ITS SUBSIDIARIES MAY DEEM NECESSARY IN ITS CREDIT EVALUATION.

FOR APPLICANT:

By: _____ Signature: _____
(Print name)

Title: _____ Date: _____

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

Authorization to Release BANK 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 _____, 20___. 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), and or on signature card.)

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.**