MEDLINE INDUSTRIES, INC., THREE LAKES DRIVE, NORTHFIELD, IL 60093
And its wholly owned consolidating subsidiaries, MedCal Sales LLC, an Illinois corporation And
Medline Industries Holdings, L.P., a Delaware corporation

CUSTOMER ACCOUNT APPLICATION FOR PHYSICIANS OFFICE

NOTE: Please complete in its entirety and fax to (847) 837-2765.

Medline Sales Representative Name and Number _____ **Group #**_____

I. SOLD TO/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.

Registered Company or DBA Applying for Credit _____

Address _____City_____ State_____Zip_____

Phone _____ Fax_____

Name of Practice _____ # of Physicians _____ Years in Business _____

Physician Name _____ Percent Owned _____ FEIN _____
(Please list ALL physicians in your practice. Use a separate sheet as needed.) (do not use social security #)

II. 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.

Corporation☐ Partnership☐ LLC☐ Limited Partnership☐ Proprietorship☐ Publicly Traded☐ Non-Profit☐

Shipping Name and Address (complete only if different than address of registered company or DBA)

_____

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

_____

Accounts Payable Phone #_____ Accounts Payable Fax #_____

Accounts Payable Contact Person: _____ Email Address: _____

IV. PAYER: (complete only if different than address of registered company or DBA/Account statements will be sent to this address)

Company Name and Address

_____

Phone _____ Contact Person_____

***TAX EXEMPTION REQUIREMENTS:** *For Tax Exemption or Resale Status, a VALID tax exemption or resale certificate MUST be received. 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.

Please select reason for exemption:

Not for Profit/Charitable _____ State/Federal Government _____ Resale _____ Direct Pay _____

Registration Number _____ State(s) _____

SIGNED AND DATED W9 IS REQUIRED TO ACTIVATE YOUR ACCOUNT

NOTICE: Prescription Drug and Prescription Device Licensing Requirements

Before placing an order for a prescription drug and/or prescription device, Medline is required to obtain a copy of a valid license that authorizes these purchases in your state. Examples of acceptable licenses are Facility Pharmacy License; Institutional Pharmacy License; Wholesale Drug (or Device) Distributor License (both, if your state has separate licenses for drugs/devices); and a Physician Authorization Form with a copy of the physician/medical director's license. Additionally, teaching institutions that are not required to obtain licenses in their state must provide a letter to certify Rx products are used for teaching purpose only. Failure to submit the appropriate license, or authorization, will result in deletion of Rx items from your order(s). Please note: the address on the license must match the address of your bill to and/or ship-to location. If you have questions regarding this Rx requirement, please contact our Medline Regulatory Affairs Department at 847-643-3884. Fax all licenses to 866-914-2586 or email us at licensing@medline.com.

☐ REQUIRED – Check this box to acknowledge understanding of the above prescription drug and prescription device requirement

CHANNELS OF TRADE:

1. Do you intend to ship or resell Medline products outside the United States, either directly or through a freight forwarding company? Y☐ N☐
2. If the answer to question 1 is yes, please identify the countries:_____.
3. Do you intend to bid on any government contracts and/or ship or resell Medline products to any governmental entity including but not limited to, military facilities, APO/FPO addresses outside the continental United States (Conus)? Y☐ N☐
4. If the answer to question No. 3 is yes, please identify the countries: _____.
5. Do you intend to sell Medline products on the internet? Y☐ N☐
6. Do you intend to resell Medline products to any third party that sells via the internet? Y☐ N☐
7. If the answer to question No. 6 is yes, please identify the third parties: _____.

TERMS: Invoices billed throughout any given calendar month are due and payable on the last day of the following month according to 30 Day End of Month payment terms. 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 Industries 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 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: _____

Email Address_____

NOTE: PLEASE COMPLETE THE ATTACHED BANK RELEASE AUTHORIZATION FORM FOR CREDIT LIMIT REQUESTS IN EXCESS OF $10,000.

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 MEDLINE INDUSTRIES, INC. 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.)

Business Name As Entered On Credit Application _____ _____

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-PLEASE EMAIL COMPLETED FORM TO bankref@medline.com OR FAX TO 847-949-3155

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