



**MEDLINE INDUSTRIES, INC., ONE MEDLINE PLACE, MUNDELEIN, IL 60060**  
**And its wholly owned consolidating subsidiaries, MedCal Sales LLC, an Illinois corporation And**  
**Medline Industries Holdings, L.P., a Delaware corporation**

**CUSTOMER CREDIT APPLICATION AND AGREEMENT**

**NOTE:** To expedite the establishment of your new account with 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, Scientific Products, 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 \_\_\_\_\_

**VI. CHANNELS OF TRADE:**

1. Do you intend to ship Medline products to a freight forwarder that, to your knowledge, will sell or ship these products outside the U.S.? Y/N
2. If the answer to question 1 is yes, please identify the countries: \_\_\_\_\_.
3. Do you intend to ship or resell Medline products outside the United States? Y/N
4. If the answer to question No. 3 is yes, please identify the countries: \_\_\_\_\_.
5. Do you intend to bid on any government contracts, and/or ship or resell Medline products to any governmental entity? Y/N
6. If the answer to question No. 5 is yes, please identify the government contracts/ent \_\_\_\_\_.
7. Do you intend to ship or resell Medline products to military facilities including, but not limited to, APO/FPO addresses outside the continental United States (CONUS) and/or Hawaii? Y/N
8. If the answer to question No. 7 is yes, please identify the facilities: \_\_\_\_\_.
9. Do you intend to sell Medline products on the internet? Y/N
10. Do you intend to resell Medline products to any third party that sells via the internet? Y/N
11. If the answer to question No. 10 is yes, please identify the third parties: \_\_\_\_\_.

**\*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 \_\_\_\_\_

**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](mailto:licensing@medline.com).

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



**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.)

**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 4<sup>rd</sup> page, please fax to 847 949 3155.**