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.

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

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. 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. Customer further agrees that it shall not resell Medline brand products to other distributors and retailers for resale purposes, but rather sell the Medline brand products only to customers for their own use. In the event Customer breaches either of the foregoing obligations, Customer shall pay Medline, as liquidated damages and not as a penalty, 15% of the price of the Products improperly acquired and or/diverted. By signing this agreement you are also authorizing Medline to send you advertisements via fax and or email.

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: _____

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 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 4rd page, please fax to 847 949 3155.