

Druzak Medical, Inc.

Call Us Toll Free

800-837-9560

order online at www.druzak.com

or Fax 724-375-1775

New Customer Information & Credit Application

Company Info

Company Name _____ Date _____
Address _____ State of Incorporation _____

Billing Info

Owner's Name (if business is not a corporation) _____
Corporate Address _____ City _____ State _____ Zip _____
Phone _____ Fax _____
Purchasing Contact _____ Credit Requested \$ _____
e-mail address _____

Shipping Info

Shipping Address (if more than one, please attach a separate sheet of paper)
Address _____ City _____ State _____ Zip _____
Phone _____ Fax _____
Purchasing Contact _____
e-mail address _____

Accounting Info

A/P Contact _____ Phone _____
Tax Exempt Number _____ Federal Tax I.D. Number _____
How long have you been in business? _____ At current location? _____

Additional Info

Type of Business Nursing Home State/County Hospital Personal Care
Number of Beds: _____
 DME Dealer Physician Non-Profit Other
Type of Entity Corporation Partnership Sole Proprietor Other _____

Important Attachments

Most recent financial statements and/or tax returns (Required for credit request of \$10,000 or more)

State Sales Tax Exemption Certificate

Trade References

(Please provide at least three trade references)

Name _____ Phone _____ Fax _____
Address _____ City _____ State _____ Zip _____

Name _____ Phone _____ Fax _____
Address _____ City _____ State _____ Zip _____

Name _____ Phone _____ Fax _____
Address _____ City _____ State _____ Zip _____

Bank Reference

Bank: _____
Address _____

Contact: _____
Phone # _____
e-mail: _____

Name and Title of Owners/Shareholders/Officers

Name: _____
Name: _____
Name: _____

Title: _____
Title: _____
Title: _____

The above statements are submitted for the purpose of obtaining credit and are believed to be true, complete and correct. I authorize investigation and verification of the references listed above to determine eligibility for an account with your company. In addition, I authorize the release of credit information from all credit reporting agencies that you contact.

Signature of Applicant _____
(signature of a duly authorized representative required)
Title _____ **Date** _____

The above signature acknowledges and accepts the terms as outlined below.

The owners/officers of all closely-held applicants requesting credit of \$10,000 or more must provide the following guarantee.

The undersigned hereby absolutely and unconditionally guarantees full and prompt payment of all sums due from the above applicant to Druzak Medical, Inc. The undersigned agrees to pay all expenses of collections as well as reasonable attorney's fees.

Signature of Guarantor _____
Date _____

Terms: Net 30 days - A Monthly service charge of 1.5% will be assessed on accounts over 30 days. This writing contains the full, final and exclusive statement of the Agreement between Druzak Medical, Inc. and Applicant and no other terms or conditions shall apply unless agreed upon in writing, signed by the authorized representative of Druzak Medical, Inc.

TERMS AND CONDITIONS

- >Standard terms are net 30 days upon approval of a signed credit application. Other payment options include Visa, MasterCard and COD. Druzak Medical will accept a company check for COD orders provided a favorable bank reference is furnished (COD is not available for drop ship orders).
- >Payment is required within 30 days from the date of invoice.
- >Credit limits are established for each account and are strictly enforced.
- >Accounts may be placed on hold if payment is past due or if the account balance is above the approved credit limit.
- >Accounts with credit limits exceeding \$30,000.00 will be required to furnish financial statements annually. Financial statements to include balance sheet and income statement.
- >Accounts with credit limits exceeding \$100,000.00 will be required to furnish financial statements quarterly. Financial statements to include balance sheet and income statement.
- >Pricing discrepancies must be addressed with customer service within 30 days from date of shipment.
- >Product can be returned for 100% credit if returned within 15 days of purchase. Product returned after 15 days of purchase will be charged a 15% restocking fee. Druzak Medical, Inc. will only accept product returned within six (6) months from date of purchase. Additional charges may apply for product returned after 90 days from date of purchase. All returns must be in full unopened cases and must be authorized by Druzak Medical Customer Service to receive credit.
- >All returns must be returned in original packaging and are subject to inspection by Druzak Medical, Inc. No credit will be issued for product that Druzak Medical, Inc. determines cannot be resold.
- >All contracts of sale shall be construed under the laws of the State of Pennsylvania and any lawsuit may be commenced within the courts of the State of Pennsylvania. Legal fees associated with the collection of delinquent accounts, the retaining of an attorney, and the court costs associated with collection of past due monies will be the responsibility of the customer.
- >Any shipping discrepancy must be reported within 48 hours from date of receipt.
- >Returned checks will be charged \$20.00 per check.
- >Accounts with past due balances will be placed on hold until the past due invoices have been paid.
- >Druzak Medical, Inc. reserves the right to withdraw open credit terms or to reevaluate credit terms and or credit limits at any time.
- >Election by Druzak Medical, Inc. to forgive delinquency, late charges or any other requirement of this Agreement as to any specific transaction with Applicant shall not be construed as a general waiver by Druzak Medical, Inc. of the conditions and requirements of this Agreement to all other credit transactions between Druzak Medical, Inc. and Applicant.