

CREDIT APPLICATION

COMPANY NAME _____

ADDRESS _____

CITY _____

STATE ZIP _____

DATE ESTABLISHED _____

PHONE _____

FAX _____

EMAIL _____

PRINCIPLES OR OFFICERS:

TYPE OF BUSINESS _____

CREDIT AMOUNT REQUESTED _____

FEDERAL TAX ID NUMBER _____

BANK INFORMATION:

BANK NAME _____

CONTACT _____

PHONE _____

FAX _____

ACCOUNT NUMBER _____

ROUTING NUMBER _____

TRADE REFERENCES:

REFERENCE #1:

NAME OF COMPANY _____
STREET ADDRESS _____
CITY, STATE, ZIP _____
PHONE _____

REFERENCE #2:

NAME OF COMPANY _____
STREET ADDRESS _____
CITY, STATE, ZIP _____
PHONE _____

REFERENCE #3:

NAME OF COMPANY _____
STREET ADDRESS _____
CITY, STATE, ZIP _____
PHONE _____

ATTACH CERTIFICATIONS AS APPLICABLE:

JCAHO CERTIFICATION
CERTIFICATE OF STATE HEALTHCARE ASSOCIATION MEMBERSHIP
TAX-EXEMPTION CERTIFICATE

- (1) BY SUBMITTING THIS APPLICATION, YOU AUTHORIZE NIDEK MEDICAL PRODUCTS, INC., TO MAKE INQUIRES INTO YOUR BANKING AND BUSINESS REFERENCES.
- (2) THIS SIGNATURE REPRESENTS THAT THE INFORMATION GIVEN WITH THIS APPLICATION IS COMPLETE AND ACCURATE.

SIGNATURE _____ DATE _____

TITLE _____