



# Account Application

Application must be completed and signed, with order attached, to initiate processing.

**NAME** \_\_\_\_\_ Parent or Subsidiary of \_\_\_\_\_

Do you or parent have an existing acct. #:  Yes  No If yes, please provide acct. #: \_\_\_\_\_

Headquarters Location \_\_\_\_\_ Are you a distributor:  Yes  No

**Billing Address** \_\_\_\_\_

City \_\_\_\_\_ County \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**Shipping Address** \_\_\_\_\_

City \_\_\_\_\_ County \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone Number w/Area Code: ( ) \_\_\_\_\_ Fax Number w/Area Code: ( ) \_\_\_\_\_

Amount of Credit Line Requested: \$ \_\_\_\_\_ Date Business Started: \_\_\_\_\_

Are Vouchers Required for Payment:  Yes  No If yes, please submit with orders. D & B #: \_\_\_\_\_

**STATE SALES TAX EXEMPT:**  Yes  No

If yes, you must provide Bound Tree Medical with a copy of your tax exemption certificate to avoid being charged taxes.

**NAME AND TELEPHONE OF PERSON RESPONSIBLE FOR ACCOUNTS PAYABLE:**

Name \_\_\_\_\_ Phone # \_\_\_\_\_ Fax # \_\_\_\_\_ Email: \_\_\_\_\_

**SHIPPING:** Complete Only  Partial Shipment Okay  Are PO's Required  Yes  No

The following persons are authorized to purchase from this account:

- 1. Name \_\_\_\_\_ Title \_\_\_\_\_
- 2. Name \_\_\_\_\_ Title \_\_\_\_\_
- 3. Name \_\_\_\_\_ Title \_\_\_\_\_

**REFERENCES (MAJOR SUPPLIERS)**

- 1. Major Supplier Name \_\_\_\_\_ Account# \_\_\_\_\_  
Phone Number w/Area Code ( ) \_\_\_\_\_ Fax Number ( ) \_\_\_\_\_ Email \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_
- 2. Major Supplier Name \_\_\_\_\_ Account# \_\_\_\_\_  
Phone Number w/Area Code ( ) \_\_\_\_\_ Fax Number ( ) \_\_\_\_\_ Email \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_
- 3. Major Supplier Name \_\_\_\_\_ Account# \_\_\_\_\_  
Phone Number w/Area Code ( ) \_\_\_\_\_ Fax Number ( ) \_\_\_\_\_ Email \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

This information is warranted to be true and is given for the purpose of obtaining credit from Bound Tree Medical. I (we) agree to pay all bills for purchases net 30 days from the date of invoice. Should legal action be instituted to enforce payment of any outstanding balance, I (we) agree to pay all costs of suit and reasonable attorney's fees.

Signature **X** \_\_\_\_\_

Print Name & Title \_\_\_\_\_ Date \_\_\_\_\_

**Please mail the completed form to:** Bound Tree Medical  
PO Box 8023  
Dublin, OH 43016-2023

**Payment Remittance Address:** Bound Tree Medical, LLC  
23537 Network Place  
Chicago, IL 60673-1235

**or Send to:** fax (866) 284-7504 **Email:** credit@boundtree.com

**TIN #:** 31-1739487

**For Internal Use Only**

Approved By \_\_\_\_\_

Date Approved \_\_\_\_\_ Terms \_\_\_\_\_ Limit \_\_\_\_\_



***Dear Valued Customer:***

In an attempt to enhance our efficiency and improve your customer experience, we are now offering you the ability to receive your invoices electronically. This green initiative will not only ensure you receive your invoices in a timely manner, but will help us to reduce excessive paper usage and reduce our carbon footprint.

To receive invoices via email or fax, please fill out the following information:

Customer Account Number: \_\_\_\_\_

Customer Name: \_\_\_\_\_

Email Address(es) (Up to 2): \_\_\_\_\_

\_\_\_\_\_

Fax Number: \_\_\_\_\_

Requester Name: \_\_\_\_\_

Contact Phone Number: \_\_\_\_\_

Please scan, email or fax this information to the following email addresses:

| <u>Company</u>     | <u>Email address</u>   | <u>Phone</u>   | <u>Fax</u>     |
|--------------------|--|----------------|----------------|
| Bound Tree Medical | <a href="mailto:credit@boundtree.com">credit@boundtree.com</a> | 1-800-282-7904 | 1-866-284-7504 |

**We encourage you to sign up for this opportunity and help us reduce our carbon footprint.**

Kind Regards,

Your Bound Tree Credit and Collections Department