



CREDIT APPLICATION FORM

▪ Business Information

Company Name: _____
 Address: _____
 City/State: _____ Zip Code: _____
 Telephone: _____ Fax: _____
 Email: _____
 A/P Contact Name: _____
 A/P Email: _____
 Member of a Buying Group: Yes No
 Sales Tax Certificate ID Number: *(attach copy)* _____

I am applying for Blend & Boost credit
 Billing Address: _____
 Type of Business: _____
 Year Established: _____
 Pharmacist License No.: _____
 DEA Registration No.: _____
 Federal Tax ID No.: _____
 NCPDP No.: _____
 Credit Request: _____

▪ Bank Information

Name: _____
 Address: _____
 City/State: _____
 Zip Code: _____

Contact Name: _____
 Account No.: _____
 Telephone: _____
 Fax: _____

▪ Credit Reference Information

Name	Address	Phone	Fax

▪ Payment Method (please choose one of the following)

<input type="checkbox"/>	Electronic Funds Transfer (EFT) / Direct Deposit (If selected, we will provide banking information).
<input type="checkbox"/>	Wire Transfer Cheque (If selected, we will provide banking information).
<input type="checkbox"/>	Cheque
<input type="checkbox"/>	Credit Card* (If selected, we will request for credit card information, we accept all major credit cards). *Please note, no credit card information is to be written on this form.

In consideration for extension of credit, debtor agrees to (1) Credit Terms of NET 30 DAYS from invoice date, and (2) in the event it becomes necessary for creditor to either bring suit or employ a collection agency to aid in the recovery of any debt owed by the debtor, the creditor shall be entitled to recover, in addition to the amount of debt due, all of its costs and attorneys fees. The signature below authorizes MEDISCA to charge interest on outstanding balances OVER 30 DAYS OLD at rate of 1.0% per month (12% per annum) or to the extent permitted by law.

Signature: _____ Title: _____
 Name: *(print)* _____ Date: _____

For Office Use Only
 Sales/CS Representative: _____ Date: _____

