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**Credit Application**

**E-A-B Medical, LLC**

www.EaBMedical.com

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Business Contact Information** | | | | | |
| *Company Name:* |  | | | | |
| *Phone:* |  | *Fax:* | | *Email:* | |
| *Address:* |  | | | | |
| *City:* |  | | *State:* | | *Zip Code:* |
| *Years in Business:* | | | ***FEIN:*** | | |
| *Sole Proprietorship:* | *Partnership:* | | *Corporation:* | | *Other:* |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Ownership** | | | | | |
| *President / Owner Name:* |  | *Address:* | |  | |
| *City:* | | *State:* | | *Zip Code:* | |
| *Treasurer Name:* |  | *Address:* | |  | |
| *City* | | *State:* | | *Zip Code:* | |
| *Secretary Name:* |  | *Address* | |  | |
| *City:* | | *State:* | | *Zip Code:* | |
| **Trade References** | | | | | |
| *Company Name:* | | | | | |
| *Address:* | | *City:* | *State:* | | *Zip Code:* |
| *Phone:* | *Fax:* | *E-Mail:* | | | |
| *Type of Account:* | | | | | |
| *Company Name:* | | | | | |
| *Address:* | | *City:* | *State:* | | *Zip Code:* |
| *Phone:* | *Fax:* | *E-Mail:* | | | |
| *Type of Account:* | | | | | |
| **Agreement** | | | | | |
| ✓To Assume responsibility for purchase by everyone authorized by the applicant or for  purchases delivered to the address of the applicant herein. | | | | | |
| **✓To pay purchases on time of order : 30-DAY Terms** | | | | | |
| ✓To pay service charge on accounts not paid as provided in the event that collection effort is  necessary to enforce collection on account. | | | | | |
| ✓To pay actual attorney fees, collection cost and court cost incurred in the event that collection effort is required or  suit is instituted to enforce to collection of said account. | | | | | |
| ✓By submitting this application, you authorize E-A-B Medical, LLC (Expand-A-Band Medical, LLC) to make inquiries into  Trade References that you have supplied. | | | | | |
| **Signatures** | | | | | |
| Title:  Date: | | Title:  Date: | | | |

***Account # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

***Approved By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

***Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

*(For E-A-B Medical, LLC use only)*

***You may send your Credit Application to:***

***Email –*** [***custserv@eabmedical.com***](mailto:custserv@eabmedical.com)

***Fax - (310) 353-2484***