Credit Application

E-A-B Medical, LLC

www.EaBMedical.com

EaB Medical
Compression Products

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:

You may send your Credit Application to:
Email – custserv@eabmedical.com
Fax - (310) 353-2484

Account # _____

Approved By: _____

Date: _____

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