



Your Premiere Source For Discount Health and Medical Products

7310 S. 3500 E. Suite C

Salt Lake City, UT 84121

Phone: 800-397-5899 Fax: 801-733-5797

www.VitalityMedical.com

CREDIT APPLICATION (Please print clearly)

Company Name _____ Contact Name _____

Tax ID# _____ - _____ Year Established _____

Address _____

City _____ State _____ Zip _____

Phone #(_____) _____ Fax #(_____) _____ Email _____

LEGAL BUSINESS STATUS:

CORPORATION PROPRIETORSHIP PARTNERSHIP OTHER

Has your company ever filed for bankruptcy protection? _____ Are you currently considering it? _____

BANK REFERENCE:

Bank Name _____ Contact Name _____ Address _____ City _____ State _____ Zip _____ Phone #(_____) _____ Fax #(_____) _____ Account # _____ Email _____

TRADE REFERENCES:

Company Name _____ Contact Name _____ Address _____ City _____ State _____ Zip _____ Phone #(_____) _____ Fax #(_____) _____ Account # _____ Email _____

Company Name _____ Contact Name _____ Address _____ City _____ State _____ Zip _____ Phone #(_____) _____ Fax #(_____) _____ Account # _____ Email _____

Company Name _____ Contact Name _____ Address _____ City _____ State _____ Zip _____ Phone #(_____) _____ Fax #(_____) _____ Account # _____ Email _____

AUTHORIZATION FOR RELEASE OF CREDIT INFORMATION:

I AUTHORIZE THE BANK AND TRADE REFERENCES LISTED ABOVE TO RELEASE CREDIT INFORMATION ABOUT MY COMPANY. ALL INFORMATION OBTAINED BY VITALITY MEDICAL, INC. FROM THESE REFERENCES WILL BE KEPT CONFIDENTIAL.

SIGNED X: _____ TITLE: _____ DATE: _____

I HEREBY APPLY FOR A CREDIT ACCOUNT WITH VITALITY MEDICAL, INC. I AM AUTHORIZED BY MY COMPANY TO REQUEST SUCH AN ACCOUNT. I UNDERSTAND THAT MY COMPANY WILL BE RESPONSIBLE FOR ANY AND ALL LEGAL FEES INCURRED BY VITALITY MEDICAL, INC. FOR THE COLLECTION OF ANY DELINQUENT INVOICES OF MY COMPANY. I FURTHER UNDERSTAND THE TERMS OF SALE ARE NET 30 DAYS FROM THE DATE OF INVOICE AND THAT DELINQUENT INVOICES OVER 45 DAYS WILL BE CHARGED A \$45 LATE FEE AND A FINANCE CHARGE OF 1.5% PER MONTH (18% ANNUALLY) AND AT THE DISCRETION OF VITALITY MEDICAL, INC., OUR COMPANY MAY BE PLACED ON A C.O.D. STATUS FOR DELINQUENT PAYMENT.

SIGNED X: _____ TITLE: _____ DATE: _____

Please complete this form, sign it, and return via Fax to: (801) 733-5797