



Your Premiere Source For Discount Health and Medical Products
 7910 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 _____ Year Established _____ Contact Name _____
 Tax ID# _____ - _____ Owner Social Security # _____ - _____ - _____ Dun & Bradstreet # _____
 Billing Address _____ City _____ State _____ Zip _____
 Shipping Address _____ City _____ State _____ Zip _____
 Phone #(_____) _____ Fax #(_____) _____ Email _____
 A/P Contact _____ Phone #(_____) _____ Email _____
 Preferred method for receiving invoices: E-mail to: _____
 (Please check one) Fax to: (_____) _____ Mail to billing address above

LEGAL BUSINESS STATUS:
 CORPORATION PROPRIETORSHIP PARTNERSHIP OTHER
 Has your company ever filed for bankruptcy protection? _____ Are you currently considering it? _____

***You must include either a fax number or e-mail address for each contact, including your bank reference. Failure to provide this may result in a delay in setting up an account with us. Please include an account number for each reference, if available.**

Bank 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 _____

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.

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 PREPAY STATUS OR CREDIT HOLD FOR DELINQUENT PAYMENT.

SIGNED X: _____ **TITLE:** _____ **DATE:** _____

PERSONAL GUARANTEE

FOR GOOD AND VALUABLE CONSIDERATION, THE UNDERSIGNED AGREES TO BE PERSONALLY LIABLE FOR ALL INDEBTEDNESS INCURRED BY THE ABOVE LISTED CORPORATION OR BUSINESS ENTITY. THE UNDERSIGNED FURTHER AGREES TO BE PERSONALLY LIABLE FOR ALL INDEBTEDNESS BASED ON THE EXTENSION OF CREDIT TO ANY OTHER CORPORATION OR BUSINESS ENTITY WITH WHICH THE UNDERSIGNED IS OR MAY BE AFFILIATED.

SIGNED X: _____ **TITLE:** _____ **DATE:** _____

Please complete this form, sign it*, and return via Fax to: (801) 733-5797
***Both signatures are required in order to process your application.**