



CREDIT APPLICATION
(Please print clearly)

Company Name _____ Contact Name _____

Tax ID# _____ - _____ Dun & Bradstreet # _____ Year Established _____

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? _____

BANK REFERENCE

*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 _____

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 PREPAY STATUS OR CREDIT HOLD FOR DELINQUENT PAYMENT.

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.