VitalityMedical.com
Add Vitality to Your Life

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 Credit Limit Requested: $_____

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:_____ SOCIAL SECURITY #:____-____-_____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.**