

Devine Medical Supplies
 12376 Washington Blvd. #103B
 Whittier, CA 90606
 Ph (562)696-8790
 Toll Free (800)609-3409
 Fax(562)696-8729

Please **fax** the signed & completed application to **(562) 696-8729**.

Ph.Toll Free(800)609-3409 Ext 711

Credit Application

Full Company Name: _____		Years in business: _____	
Street Address: _____	City: _____	State: _____	Zip Code: _____
Mailing Address: _____	City: _____	State: _____	Zip Code: _____
Telephone Number () - ext: _____	AP Contact Name: _____		Title: _____
Credit Limit Requested: \$ _____	Do you use P.O.'s? Yes: <input type="checkbox"/> No: <input type="checkbox"/>	Has business/officer filed for Bankruptcy? Yes: <input type="checkbox"/> No: <input type="checkbox"/>	
Business Structure:			
Corporation: <input type="checkbox"/>	State of Incorporation: _____	Proprietorship: <input type="checkbox"/>	Partnership or L.L.C.: <input type="checkbox"/>
Subsidiary Branch/Division? Yes: <input type="checkbox"/> No: <input type="checkbox"/>		If Yes: Name/Address of Parent: _____	
Email Address: _____	Internet Address: _____	Federal Tax ID #: _____	
Name of Principals:			
President: _____		Vice President: _____	
Chief Financial Officer: _____		Controller: _____	
Information:			
Principal I: _____	Home Address: _____	City: _____	State: _____
Zip Code: _____	Home Phone: _____	Social Security #: _____	
Principal II: _____	Home Address: _____	City: _____	State: _____
Zip Code: _____	Home Phone: _____	Social Security #: _____	

Bank and/or Lender References (list all secured parties):			
1. Name and Address: _____		Phone # _____	
Contact Name: _____	Line of Credit: \$ _____	Account # _____	
2. Name and Address: _____		Phone # _____	
Contact Name: _____	Line of Credit: \$ _____	Account # _____	
Trade References:			
1. Name and Address: _____		Phone #: _____	Contact Name: _____
2. Name and Address: _____		Phone #: _____	Contact Name: _____
3. Name and Address: _____		Phone #: _____	Contact Name: _____

I/We agree to make all payments within our **30-day** term with Devine Medical. A late fee 2% per month may be added to any invoice that is not paid within **30 days**. We may report information about my/our account to credit bureaus. Late payments, missed payments, or other defaults on my/our account may be reflected in our credit report. If it becomes necessary to file a lien, suit or engage a collection agency or attorney, I/We agree to bear all expenses incurred (whether or not a suit is filed), including but not limited to attorney fees, court costs and interest, plus default interest at 2 % per month. I/We agree and acknowledge that the Superior Court of California , in and for the County of Los Angeles, is the proper venue and jurisdiction for the litigation of, or performance of, any matters relating to this credit application, or the account. I hereby release any and all credit or financial information to Devine Medical or its assignees; By signing I am accepting your conditions of sales.

SIGNATURE

DATE