



# Credit Application

1931 Norman Drive South  
Waukegan, IL 60085-6715  
PH.: (800) 728-6811  
FAX: (800) 687-7201

**Failure to complete this form could result in delay of credit approval - Fax numbers MUST be included**  
**Please print clearly**

SALES REP NAME / NUMBER: \_\_\_\_\_ WEBSITE \_\_\_\_\_

TRADE NAME: \_\_\_\_\_

LEGAL NAME: \_\_\_\_\_ BILL TO: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ ADDRESS: \_\_\_\_\_

CITY, STATE, ZIP: \_\_\_\_\_ CITY, STATE, ZIP: \_\_\_\_\_

PHONE: ( ) \_\_\_\_\_ FAX: ( ) \_\_\_\_\_

COMPANY E-MAIL ADDRESS: \_\_\_\_\_

PARENT COMPANY NAME: \_\_\_\_\_ ADDRESS: \_\_\_\_\_

YEARS IN BUSINESS: \_\_\_\_\_

TYPE OF BUSINESS: \_\_\_\_\_

DBA:  INDIVIDUAL (Owner's name)  PARTNERSHIP  CORPORATION (Officer & Title)

BUYING GROUP NAME & NUMBER: \_\_\_\_\_

RESALE TAX EXEMPTION #: \_\_\_\_\_ PHARMACY CERTIFICATE # & EXP. DATE: \_\_\_\_\_

Please provide copy of tax exempt certificate

**OFFICER'S NAMES**

**TITLE**

**ACCOUNTS PAYABLE CONTACT**

\_\_\_\_\_  
NAME: \_\_\_\_\_

\_\_\_\_\_  
PHONE NO.: ( ) \_\_\_\_\_

**BANK REFERENCES: Fax number MUST be included**

CHECKING ACCOUNT NO.: \_\_\_\_\_ SAVINGS #: \_\_\_\_\_ LOAN #: \_\_\_\_\_

NAME OF BANK: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CONTACT: \_\_\_\_\_ PHONE: ( ) \_\_\_\_\_ FAX: ( ) \_\_\_\_\_

**TRADE REFERENCES: Fax numbers MUST be included**

(1) NAME: \_\_\_\_\_ ACCOUNT NO.: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

TEL: ( ) \_\_\_\_\_ FAX: ( ) \_\_\_\_\_

(2) NAME: \_\_\_\_\_ ACCOUNT NO.: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

TEL: ( ) \_\_\_\_\_ FAX: ( ) \_\_\_\_\_

(3) NAME: \_\_\_\_\_ ACCOUNT NO.: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

TEL: ( ) \_\_\_\_\_ FAX: ( ) \_\_\_\_\_

*The undersigned confirms that the above information is true and accurate and hereby authorizes DMS Holdings Inc., d/b/a MABIS Healthcare and/or Duro-Med Industries to obtain credit and/or financial information from the bank and references listed above. If given open terms of credit with MABIS Healthcare and/or Duro-Med Industries, the undersigned promises to pay for all purchases in accordance with those terms. The undersigned guarantees payment of all invoices. If at any time the undersigned is unable to meet its financial obligations with MABIS Healthcare and/or Duro-Med Industries, the undersigned agrees to pay for legal, court or any other fees necessary to collect unpaid invoices. The undersigned also consents to receive faxes, emails and mailings on behalf of MABIS Healthcare and/or Duro-Med Industries and its subsidiaries and affiliates.*

AUTHORIZED SIGNATURE \_\_\_\_\_ TYPE OR PRINT NAME \_\_\_\_\_ DATE \_\_\_\_\_

TITLE: \_\_\_\_\_

**Credit will not be extended without a signed Credit Application**