2202 W Lone Cactus Dr., Suite 15
Phoenix, AZ 85027
P: 888-566-3778 F: 888-959-0393
inbox@salusmedicalrx.com

Standard Customer Application

Business Name:		
Bill To Address:		
City	**State:**	**Zip:**
Phone:	**Fax:**	
Email: ***(Valid email address is required for regulatory notifications)***		
Ship To Address: **(If different from the address listed above)**		
City	**State:**	**Zip:**
Phone:	**Fax:**	
Email: ***(Valid email address is required for regulatory notifications)***		
Business Information: ☐ **Clinic** ☐ **GPO** ☐ **Wholesaler** ☐ **Pharmacy** ☐ **LTC** ☐ **Other:**		
DEA #: **Exp. Date:**	**State License #:**	**Exp. Date:**
**** A current copy of your State Pharmacy license and DEA certificate must be sent along with this application.***		
Accounts Payable Contact: Name / position: Phone / Email:		
Authorized Buyer: Name / Position: Phone / Email:		
Officers or Owners: Name / Position: Phone / Email:		

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Credit Application Agreement

Business Name:		**FEIN:**	
Address:	**City:**	**State:**	**Zip:**
Phone:	**Fax:**		
Email:			
☐ **Corporation** ☐ **Partnership** ☐ **Sole Proprietor** ☐ **LLC**			
Proprietor, Partners or officers Name: Home Address: Soc. Sec. #			
Proprietor, Partners or officers Name: Home Address: Soc. Sec. #			
Driver's License # of Owners:			
Bookkeeper:		**Manager:**	
Date Business Established:		☐ **Lease Building**	☐ **Own**
How long under present Ownership?		**Credit Requested:**	
Primary Supplier:	**Phone:**	**Fax:**	
Secondary Supplier:	**Phone:**	**Fax:**	
Other Trade Supplier:	**Phone:**	**Fax:**	
Name of Bank:		**Account No:**	
Address:			
Bank Officer:			

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EXPRESS TERMS, CONDITIONS AND SIGNATURE

The information and statements in this application are true, correct, and complete and are made for the purpose of including Salus Medical, LLC. to establish an open account line of credit and open book account. Salus Medical, LLC. is hereby expressly authorized to obtain any information it considers necessary from any source concerning the statement in this application. In consideration of, and in order to include Salus Medical, LLC. to establish an open account based on the foregoing agreement, the applicant promises to pay all purchases on the terms as set forth on the invoices. If at any time, for any reason, the applicant is unable to pay for purchases when due, the applicant agrees to pay and authorizes Salus Medical, LLC. to bill our account for interest computed at the rate of 10% per annum or the maximum amount allowed by law if not 10% per annum on any past due amount owing on my/our account. In the event it becomes necessary to incur collection costs or institute suit to collect any amount due under this agreement or any portion thereof, the applicant promises to pay such additional collection costs, charges and expenses including reasonable attorney's fees. The undersigned is signing this agreement in two capacities, both for the company applicant and as an individual. I, the undersigned, in my individual personal capacity, by this agreement do expressly personally, unconditionally, jointly, severally, irrevocably and continually personally guarantee to pay the indebtedness of the company applicant to Salus Medical, LLC. for all goods and merchandise purchased by the company applicant. In so doing, I, the undersigned, expressly warrant and represent that I have read and understand this entire agreement and it is my intention by signing this agreement to personally guaranty and assume joint and several responsibilities to Salus Medical, LLC. along with the company applicant.

Signature: Print Name: Date:

PLEASE ENTER ALL INFORMATION ON THE APPLICATION & SIGN TO AVOID DELAYS

**I certify under penalty of perjury that the forgoing information is true and correct. I also agree to contact Salus Medical, LLC. if there is any change in the regulatory status of this Business such as a change in licensure or ownership.*

Authorized Signature:_____

Name: **Title:** **Date:**

Office Use Only

Customer #:

Salesperson: