PO BOX 850247
MOBILE, AL 36685-0247
PH: 800-461-1370
FX: 251-660-7533
www.SupremeMedical.com

CREDIT APPLICATION

Company Name:				Date:
Legal Business Name:				State of Incorporation:
Owner's/Partner's/Officer's Name:				
Shipping Address:		City:	State:	Zip:
Phone:	Fax:	Federal Tax I.D. Number:		D&B#
Purchasing Agent:		Purchasing E-mail:		
Billing Address:		City:	State:	Zip:
Accounts Payable Supervisor:		Phone:	Fax:	
Accounts Payable E-mail:		Years at this address:	Date Business Began:	

Tax Status: ☐ Taxable ☐ Resale ☐ Exempt Organization

**** Attach Resale\Exempt Tax Certificate with Application ****

Type of Business	☐ Assisted Living	☐ E-Commerce	☐ Government	☐ HME Provider	☐ Home Health	☐ Hospice	☐ Mail Order Provider
	☐ Hospital	☐ Nursing Home	☐ Pharmacy	☐ Physician	☐ Podiatry	☐ Physical Therapy\Rehab	☐ Wound Mgmt.

Type of Ownership	Corporation ☐	Partnership ☐	Sole Proprietor ☐	Other :

If above address is a subsidiary, please provide parent company Headquarters information:			
Name (if different than above):	Phone:	Fax:	
Address:	City:	State:	Zip:

TRADE REFERENCE *Please provide **at least three** medical supply or medical manufacturer references*

Name:	Phone:	Fax:	Acct#	
Address:		City:	State:	Zip:
Name:	Phone:	Fax:	Acct#	
Address:		City:	State:	Zip:
Name:	Phone:	Fax:	Acct#	
Address:		City:	State:	Zip:
Name:	Phone:	Fax:	Acct#	
Address:		City:	State:	Zip:

Please mark which manufacturers you have accounts with for additional trade reference information: **(include your account#)**

☐ Convatec Account# ____________________ ☐ Hollister Account# ________________ ☐ Coloplast Account# ________________

☐ Smith&Nephew Account# ________________ ☐ Kendall Account# ___________________ (Covidien) ☐ Medlift Account# ___________________

Fax Completed Application to (251) 660-7533 Attention: Credit Department

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BANK REFERENCE *Please provide at least one banking reference*

Type of Account: ☐ **Checking** ☐ **Savings**		
Bank Name:	Bank Contact:	
Account Number:	Phone:	Fax:
Address:		

Type of Account: ☐ **Checking** ☐ **Savings**		
Bank Name:	Bank Contact:	
Account Number:	Phone:	Fax:
Address:		

ACKNOWLEDGEMENT & AUTHORIZATION AGREEMENT

The information on this form is submitted for the purpose of obtaining credit and is believed to be true, complete and correct. Supreme Medical Fulfillment Systems, Inc. is hereby authorized to obtain credit and/or financial information from my/our bank(s) or other commercial firms with whom I/We have done business. It is understood that such credit and/or financial information will be held in strict confidence and used only in consideration of this application. Only upon approval of this application, it is agreed that all purchases will be paid in full in accordance to the terms of sale stated on Supreme Medical's invoices. Personal Guarantee: The undersigned, in consideration of Supreme Medical's agreement to sell its medical products to Applicant personally guarantees the full and prompt performance and compliance by Applicant of all terms and conditions of this Credit Agreement, and the terms of sale stated on Supreme Medical's invoices. Furthermore, the undersigned personally guarantees the full payment of all outstanding indebtedness of the Applicant to Supreme Medical Fulfillment Systems, Inc. upon request by Supreme Medical. Supreme Medical retains a security interest in all goods sold until the full Supreme Medical purchase price has been paid. Should I/We fail to pay Supreme Medical according to stated terms, it is understood that Supreme Medical shall have the right to take immediate possession of the goods sold and not paid for. In the event that Supreme Medical must use third-party assistance for collection of any delinquent balance due, I/We agree to pay interest at the rate of 1-1/2% per month (or such other rate allowed by prevailing law), reasonable attorney fees, collection fees and/or incurred court costs allowed by law. The undersigned agrees to notify Supreme Medical by certified mail of any change in ownership of the customer and further agrees to be liable for all purchases should the undersigned fail to comply with said notification. Supreme Medical Fulfillment Systems, Inc. is hereby authorized the right to send info to my/our facility via phone, mail, fax, or e-mail. A faxed copy of the signed application shall be considered the original. Returned Checks are subject to returned check charges.

Signed By________________________ ➢ **Officer or Authorized Agent Signature** **Print Name** ________________________	**Officer's Home Address** __________________ ______________________________ **Social Security Number** __________________	**Date** ______________

*Note: Credit application **must be signed** by a company officer in order to process application.*

** Do not write below. Authorization for Supreme Medical internal use only **

Approval Date:	
Approved By:	
Terms:	
Credit Limit:	
Sales Rep:	

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