PHONE: 813-522-1687 **EMAIL**: BRIDGEMEDPRO@GMAIL.COM **FAX**: 813-441-7283

Credit Application

GENERAL INFORMATION

LEGAL CORPORATE NAME | ( ) PHONE | ( ) FAX

D.B.A. NAME FEDERAL ID # | FEDERAL ID #

BILLING ADDRESS | SHIPPING ADDRESS

CITY STATE ZIP | CITY STATE ZIP

Phone Fax | Phone Fax

CC# EXP DATE CVS# | Credit Card Billing Address

Type of Business:

□ Proprietorship □ Partnership □ Limited Partnership □ LLC □ (S) Corp □ (C) Corp □ Other

State of Incorporation Year Business Started | Tax Exempt? Tax Exempt #

Accounts Payable Contact | Accounts Payable Contact E-mail

OFFICERS, PARTNERS OR OWNERS OF THE BUSINESS

Name Title % Owned | Name Title % Owned

Name Title % Owned | Name Title % Owned

We warrant this information to be true. I, AN AUTHORIZED OFFICER, grant permission to investigate the references, including commercial and consumer credit checks. I agree to pay within agreed terms. Purchaser agrees to pay all invoices within 30 days of the invoice date. If an invoice reaches 15 days past the due date the purchaser authorizes Bridge Medical Products LLC to charge the credit card above for that balance. A late charge of 1.5% per month may be imposed upon the accrued, unpaid balance of an invoice not paid within terms. We agree to pay assessed interest up to the highest amount allowed by law. If the account is placed for collection, or with an attorney, whether a lawsuit is filed or otherwise, or if services of an attorney are required to protect the interest of Bridge Medical Products LLC, we agree to pay all costs and reasonable attorney's fees, and further consent that jurisdiction and venue shall be in the circuit courts of Wesley Chapel, FL

We hereby grant permission to Bridge Medical Products LLC. and its subsidiaries to send advertising and promotional materials to the email(s) and fax numbers(s) listed above. This operates as consent under the 47 U.S.C. § 227 of the Telephone Consumer Protection Act.

Signature Date

Print Name Print Title

Initials _____

COMPANY NAME:_____**(as listed on first page)**

BUSINESS INFORMATION

TAX STATUS: Taxable □ Exempt □
If exempt, you must provide one of the following for all "ship-to" states
Exemption Certificate □ Resale Certificate □ Other □ (Direct Pay Permit, Manufacturing Certificate)

Are you a member of a Group Purchasing Organization? Yes □ No □ If yes, please provide name:

Business References (Please provide at least three medical supply or medical manufacturer references.)

Name_____Phone_____Fax_____Account #_____

Address_____City_____State____Zip_____

Name_____Phone_____Fax_____Account #_____

Address_____City_____State____Zip_____

Name_____Phone_____Fax_____Account #_____

Address_____City_____State____Zip_____

Bank Reference

Name | Account Number

Address | Telephone #

City State Zip | Fax #

Guaranty

To induce Bridge Medical Products LLC to sell goods to the Applicant, the undersigned agrees to the above terms which are herein incorporated, and personally guarantees and agrees to pay, when due, and upon demand, the full amount of any indebtedness, including attorney fees and costs incurred for collections, owed to Bridge Medical Products LLC by the applicant in connection with such sales.

Guarantors Signature | Date | Printed Name of Guarantor | Social Security No.

Guarantors Signature | Date | Printed Name of Guarantor | Social Security No.

Initials _____