



Credit Application

800 N Clark St., Albion, MI 49224

PLEASE FAX THIS COMPLETED FORM TO: 1-517-686-1072

GENERAL INFORMATION:

Company: _____
Address: _____
City: _____ Prov/State: _____ Postal/Zip Code: _____
Phone: _____ Fax: _____
Type of Business: _____ Federal ID #: _____
Years in Business: _____ PST #: _____ GST #: _____
President: _____
General Manager: _____
Controller: _____
A/P Supervisor: _____
Bank: _____ Telephone #: _____
Address: _____

TRADE REFERENCES:

Company: _____ Tel #: _____
Address: _____ Fax #: _____
City: _____ Prov/State: _____ Postal/Zip Code: _____

Company: _____ Tel #: _____
Address: _____ Fax #: _____
City: _____ Prov/State: _____ Postal/Zip Code: _____

Company: _____ Tel #: _____
Address: _____ Fax #: _____
City: _____ Prov/State: _____ Postal/Zip Code: _____

Credit Agreement

I understand the following and will abide by the following.

1. Notify **MedCaster** of any changes in ownership of our company.
2. If granted credit our company agrees to pay all invoices within 30 days of invoice date.
3. It is agreed that our account will become C.O.D. if we fail to pay invoices within the stated above terms. Terms will then be reviewed.
4. Our company financial condition is satisfactory and can meet all financial obligations.
5. There are no lawsuits or judgments against me at this present time. If our company defaults on payment of any outstanding valid invoices we agree to pay attorney and/or collection expenses.

I agree to pay my account within the terms and authorize you to obtain such information as you may require concerning this application.

Date _____ Sign _____

Personal Guarantee: _____ Title _____