

Business Information

Legal Name: _____ Bill to Address: _____
 Doing Business as: _____ Type of Business: _____
 Ship to Address: _____ Pharmacy State License No.: _____
 State: _____ DEA Registration No.: _____
 City: _____ Zip Code: _____ State Controlled Sub. License No. (if applicable): _____
 Telephone: _____ Fax: _____ NCPDP No.: _____
 Email: _____ Resale Tax Certificate ID No.: _____
 A/P Contact Name: _____ Member of Buying/GPO Group: Yes No _____
 (Please Specify)
 A/P Email: _____ Pharmacy Chain: Yes No _____
 (Please Specify)

Payment Options

Net 30 Credit Card at time of Sale ACH on Due Date EFT (direct deposit)
 Send my Invoices Via: I will obtain online Email: _____ Fax: _____
 Send my Statements Via: I will obtain online Email: _____ Fax: _____
 Ownership: Sole Proprietor Partnership Corporation LLC Years in Business: _____ DUNS #: _____
 Previous Account: Yes No If Yes, Customer # _____

Bank Information

Name: _____ Contact Name: _____
 Address: _____ Account No.: _____
 City/State: _____ Zip Code: _____ Telephone: _____ Fax: _____

Credit Reference Information

Name	Address	Phone	Fax

In consideration for extension of credit, debtor agrees to (1) Credit Terms of NET 30 DAYS from invoice date, and (2) in the event it becomes necessary for creditor to either bring suit or employ a collection agency to aid in the recovery of any debt owed by the debtor, the creditor shall be entitled to recover, in addition to the amount of debt due, all of its costs and attorneys fees. The signature below authorizes MEDISCA to charge interest on outstanding balances OVER 30 DAYS OLD at rate of 1.0% per month (12% per annum) or to the extent permitted by law.

SIGNATURE: _____ **TITLE:** _____
NAME: (print) _____ **DATE:** _____

Office Use Only – Customer Number

Sales Reps. Tagged	Terms Agreed	Approved Credit	Customer No. Assigned	
1 -				
2 -				
3 -			ISR No.: _____	WHS No.: _____
4 -				