THOMAS MEDICAL
a MedGyn company

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# NEW CUSTOMER APPLICATION

Please complete and email back to: sales@thomasmedical.com

| **Billing Address** | | **Shipping Address:** | |
|---|---|---|---|
| Name: | | Name: | |
| Address: | | Address: | |
| City, State, Zip: | | City, State, Zip: | |
| Bill to GLN #: | | Ship to GLN #: | |

| | | | | | |
|---|---|---|---|---|---|
| A/P Contact: | | Phone# | | Fax# | |
| Buyer Contact: | | Phone# | | Fax# | |
| Alt. Contact: | | Phone# | | Fax# | |

**Electronic Invoicing:** Check box to receive invoices electronically via e-mail instead of USPS mail. ☐

Electronic Invoicing E-Mail Address: _____

**Type of Business:**

☐ Distributor ☐ Physician

☐ Clinic ☐ Government

☐ Hospital

**EIN (if applicable):** _____

(Medical license information required for Account to be established)

**Medical License Validation:**

| | |
|---|---|
| Primary Physician/Pharmacist: | |
| Medical/Pharmacist License #: | |
| Physician/Pharmacist Signature: | |

**Tax Status:** ☐ Taxable ☐ Tax Exempt Certificate Attached (Please Attach Certificate) ☐ Resale (Please Attach Certificate)

**Preferred Shipping Method:**

☐ UPS Ground ☐ FedEx ☐ Best Way Other: _____

**Bill Shipping to:**

☐ Pre-Pay & Add ☐ Carrier Account # _____

Applicant agrees to pay all items within the terms granted, and if upon default, agrees to pay applicable interest or service charges, and/or collection costs associated with collecting the debt, including reasonable attorney's fees. The Undersigned warrants that all information provided is true and correct, and hereby grants authorization to verify information by checking past credit history and investigating references to determine credit worthiness.

**Signature:** _____ **Printed Name:** _____ **Date:** _____

For Internal Use Only

Customer Account Number: _____ Credit Limit: _____ Payment Terms: _____ Established Date: _____ Reviewed By: _____