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#		Email	
Buyer Contact:		Phone#		Email	
Alt. Contact:		Phone#		Email	

Electronic Invoicing E-Mail Address: _____

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

Type of Business:

☐ Distributor ☐ Clinic ☐ Hospital ☐ Physician ☐ Government

EIN (if applicable): _____

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: _____