Swift Medical

CREDIT APPLICATION FOR A BUSINESS ACCOUNT

BUSINESS CONTACT INFORMATION			
Title:			
Company name:			
Phone:	Fax:	E-mail:	
Registered company address:			
City:		Prov.:	Postal Code:
Date business commenced:			
Sole proprietorship:	Partnership:	Corporation:	Other:

BUSINESS AND CREDIT INFORMATION			
Primary business address:			
City:		Prov.:	Postal Code:
How long at current address?			
Telephone:	Fax:	E-mail:	
Bank name:			
Bank address:		Phone:	
City:		Postal Code:	Postal Code:
Type of account:	Account number:		
Savings			
Checking			
Other			

BUSINESS/TRADE REFERENCES			
Company name:			
Address:			
City:		Postal Code:	Postal Code:
Phone:	Fax:	E-mail:	
Type of account:			
Company name:			
Address:			
City:		Postal Code:	Postal Code:
Phone:	Fax:	E-mail:	
Type of account:			
Company name:			
Address:			
City:		Postal Code:	Postal Code:
Phone:	Fax:	E-mail:	
Type of account:			

AGREEMENT

1. All invoices are to be paid 30 days from the date of the invoice.
2. Claims arising from invoices must be made within seven working days.
3. By submitting this application, you authorize Swift Medical to make inquiries into the banking and business/trade references that you have supplied.

SIGNATURES

Title:	Title:
Date:	Date: