Swift Medical Credit Application

Business Contact Information			
Title:			
Company name:			
Phone:	Fax:	E-mail:	
Registered company address:			
City:		State:	ZIP Code:
Date business commenced:			
Sole proprietorship:	Partnership:	Corporation:	Other:
Federal Tax ID (EIN) number (required):			
Business and Credit Information			
Primary business address:			
City:		State:	ZIP Code:
How long at current address?			
Telephone:	Fax:	E-mail:	
Bank name:			
Bank address:		Phone:	
City:		State:	ZIP Code:
Type of account:	Account number:		
Savings			
Checking			
Other			
Business/trade references			
Company name:			
Address:			
City:		State:	ZIP Code:
Phone:	Fax:	E-mail:	
Type of account:			
Company name:			
Address:			
City:		State:	ZIP Code:
Phone:	Fax:	E-mail:	
Type of account:			
Company name:			
Address:			
City:		State:	ZIP 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 Inc. to make inquiries into the banking and business/trade references that you have supplied.

Signature

_____

Authorization Signature

Name: _____ Title: _____ Date: _____