Account Application

Application must be completed and signed, with order attached, to initiate processing.

NAME ______________________ Parent or Subsidiary of ______________________

Do you or parent have an existing acct. #: ☐ Yes ☐ No If yes, please provide acct. #: ______________________

Headquarters Location ______________________ Are you a distributor: ☐ Yes ☐ No

Billing Address ______________________

City ______________ County ______________ State ________ Zip ________

Shipping Address ______________________

City ______________ County ______________ State ________ Zip ________

Phone Number w/Area Code: (   ) ______________ Fax Number w/Area Code: (   ) ______________

Amount of Credit Line Requested: $ ______________ Date Business Started: ______________

Are Vouchers Required for Payment: ☐ Yes ☐ No If yes, please submit with orders. D & B #: ______________

STATE SALES TAX EXEMPT: ☐ Yes ☐ No If yes, you must provide DXE Medical with a copy of your tax exemption certificate to avoid being charged taxes.

NAME AND TELEPHONE OF PERSON RESPONSIBLE FOR ACCOUNTS PAYABLE:

Name ______________ Phone # ______________ Fax # ______________ Email: ______________

SHIPPING: Complete Only ☐ Partial Shipment Okay ☐ Are PO's Required ☐ Yes ☐ No

The following persons are authorized to purchase from this account:

1. Name ______________________ Title ______________
2. Name ______________________ Title ______________
3. Name ______________________ Title ______________

REFERENCES (MAJOR SUPPLIERS)

1. Major Supplier Name ______________________ Account# ______________
   Phone Number w/Area Code (   ) ______________ Fax Number (   ) ______________ Email ______________
   Address ______________ City ______________ State ________ Zip ________
2. Major Supplier Name ______________________ Account# ______________
   Phone Number w/Area Code (   ) ______________ Fax Number (   ) ______________ Email ______________
   Address ______________ City ______________ State ________ Zip ________
3. Major Supplier Name ______________________ Account# ______________
   Phone Number w/Area Code (   ) ______________ Fax Number (   ) ______________ Email ______________
   Address ______________ City ______________ State ________ Zip ________

This information is warranted to be true and is given for the purpose of obtaining credit from DXE Medical. I (we) agree to pay all bills for purchases net 30 days from the date of invoice. Should legal action be instituted to enforce payment of any outstanding balance, I (we) agree to pay all costs of suit and reasonable attorney's fees.

Signature X ______________________________________

Print Name & Title ______________________________ Date ______________

Please email the completed form to: sales@dxemed.com

or Fax to: **Toll Free** 844-318-0590
Local 614-760-5330

Payment Remittance Address: DXE Medical, Inc.
Attn: Accounts Receivable
PO Box 8023
Dublin, OH 43016

For Internal Use Only

Approved By ______________________

Date Approved ______________ Terms ______________ Limit ______________

Dear Valued Customer:

In an attempt to enhance our efficiency and improve your customer experience, we are now offering you the ability to receive your invoices electronically. This green initiative will not only ensure you receive your invoices in a timely manner, but will help us to reduce excessive paper usage and reduce our carbon footprint.

To receive invoices via email or fax, please fill out the following information:

Customer Account Number: ______________________________________

Customer Name: ______________________________________

Email Address(es) (Up to 2): ______________________________________

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Fax Number: ______________________________________

Requester Name: ______________________________________

Contact Phone Number: ______________________________________

Please scan, email or fax this information to the following email addresses:

Company	Email address	Phone	Fax
DXE Medical	credit@dxemed.com	1-866-349-4363	1-866-284-7504

We encourage you to sign up for this opportunity and help us reduce our carbon footprint.

Kind Regards,

Your DXE Credit and Collections Department