State and Municipal 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. #: _____

Billing Address _____

City _____ County _____ State _____ Zip _____

Shipping Address _____

City _____ County _____ State _____ Zip _____

Telephone Number w/Area Code: _____

Fax Number w/Area Code: _____

Are Vouchers Required for Payment: ☐ Yes ☐ No If yes, please submit with orders.

Amount of Credit Line Requested: _____

Funding Derived From: ☐ Local Government ☐ Donations ☐ Other: _____

FEIN #: _____ **Account Manager:** _____

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 Number _____

Fax Number _____ 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 _____

Signature X Print _____

Name & Title _____ Date _____

Please mail the completed form to:
DXE Medical, Inc.
1001 Flagpole Court
Brentwood, TN 37027

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): _____

_____

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