Cardio Partners

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 Cardio Partners 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 Cardio Partners. 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: Cardio Partners
29170 Network Place
Chicago, IL 60673-1291

For Internal Use Only

Approved By _____

Date Approved _____ Terms _____ Limit _____

Cardio Partners

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
Cardio Partners	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 Cardio Partners Credit and Collections Department