

New Account Information



Customer Name _____

Email Address _____

Sales Rep: _____ GPO Affiliation: _____

8020 Tyler Blvd.
Mentor, OH 44060

Date: _____

Please fill out the form completely and **fax** to **(440) 701-1482**. This information will be used to set up your account and must be accurate and legible.

Bill to/Ship to Name: _____

Bill to/Ship to Address: _____

City: _____ State: _____ Zip: _____

Primary Contact Name: _____

Primary Contact Phone: _____ Fax: _____

Anticipated Sales Volume: _____ Years in Business: _____

Taxable: YES _____ NO _____ (If no, attach Tax Exemption Certificate and return with this sheet)

Organization Individual: _____ Partnership: _____ Corporation: _____ Type of Business: _____

Tax I.D. #: _____ DUNS #: _____

Ordering Pharmacy %RX+items? YES _____ NO _____ If yes, Provide State Pharmacy License# _____

Service on Equipment? YES _____ NO _____ If yes make, model and serial# _____

Principals, Partners, and Officers:

Name: _____ Title: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Name: _____ Title: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Name: _____ Title: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Bank & Trade Reference:

Bank Name: _____ Branch: _____ City: _____ State: _____

Phone Number: _____ Fax: _____ Contact: _____

Type of Account: _____ Account Number: _____

Trade Reference: _____ City: _____ State: _____

Phone Number: _____ Contact: _____

Trade Reference: _____ City: _____ State: _____

Phone Number: _____ Contact: _____

The undersigned certifies the above information given for credit purposes is true and authorizes SourceOne Healthcare Technologies, Inc to investigate references. The undersigned authorizes all parties to release credit and financial information requested as a process of said investigation.

Name: _____ Signature: _____ Date: _____