MEDISCA PHARMACEUTIQUE INC.

CREDIT APPLICATION FORM
CANADA

▪ Business Information

Company Name: _____ Billing Address: _____

Ship to Address: _____ PST: _____

City/Province: _____ Year Established: _____

Postal Code: _____ Pharmacist/Healthcare Professional License: _____

Telephone: _____ Fax: _____ Drug Establishment License (if applicable): _____

Email: _____ GST No.: _____

A/P Contact Name: _____ QST No.: _____

A/P Email: _____ Credit Request: _____

☐ I hereby give consent to receive electronic communications from THE MEDISCA Group of Companies for marketing purposes.

▪ Payment Options

☐ Net 30 ☐ Credit Card at time of Sale ☐ EFT/ACH on Due Date

Send my Invoices Via: ☐ I will obtain online ☐ Email: _____ ☐ Fax: _____

Send my Statements Via: ☐ I will obtain online ☐ Email: _____ ☐ Fax: _____

Ownership: ☐ Sole Proprietor ☐ Partnership ☐ Corporation ☐ LLC Years in Business: _____ ☐ DUNS #: _____

Previous Account: ☐ Yes ☐ No If Yes, Customer # _____

▪ Bank Information

Name: _____ Contact Name: _____

Address: _____ Account No.: _____

City/Province: _____ Postal Code: _____ Telephone: _____ Fax: _____

▪ Credit Reference Information

Name	Address	Phone	Fax

In consideration for extension of credit, debtor agrees to (1) Credit Terms of NET 30 DAYS from invoice date, and (2) in the event it becomes necessary for creditor to either bring suit or employ a collection agency to aid in the recovery of any debt owed by the debtor, the creditor shall be entitled to recover, in addition to the amount of debt due, all of its costs and attorneys fees. The signature below authorizes MEDISCA to charge interest on outstanding balances OVER 30 DAYS OLD at rate of 1.0% per month (12% per annum) or to the extent permitted by law.

Signature: _____ Title: _____

Name: *(print)* _____ Date: _____

▪ Office Use Only – Customer Number

Sales Reps. Tagged	Terms Agreed	Approved Credit	Customer No. Assigned	
1 -				
2 -				
3 -			ISR No.: _____	WHS No.: _____
4 -				