MEDISCA INC.®

CREDIT APPLICATION FORM
UNITED STATES

▪ Business Information

Legal Name: ______________________ Bill to Address: ______________________

Doing Business as: ______________________ Type of Business: ______________________

Ship to Address: ______________________ Pharmacy State License No.: ______________________

City/State: ____________ Zip Code: ____________ DEA Registration No.: ______________________

Telephone: ____________ Fax: ____________ State Controlled Sub. License No. (if applicable): ____________

Email: ______________________ NCPDP No.: ______________________

A/P Contact Name: ______________________ Resale Tax Certificate ID No.: ______________________

A/P Email: ______________________ Member of Buying/GPO Group: ☐ Yes ☐ No ____________ (Please Specify)

Pharmacy Chain: ☐ Yes ☐ No ____________ (Please Specify)

▪ 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/State: ____________ Zip 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 -				