



**PO Box 1829
Oldsmar, FL 34677**

**www.universalmedicalinc.com
order@universalmedicalinc.com**

To whom it may concern:

The following is an application for credit. Please ensure that all information is completed as incomplete applications cannot be processed.

If you have already placed an order, please indicate the order reference number in the indicated field. This will expedite processing once your account is approved. If you have not yet placed your order, please include it with your completed credit application for expedited processing.

Once you have completed the application, please email a copy to order@universalmedicalinc.com.

Our accounts receivable department will immediately contact your trade references. The amount of time required for processing credit applications varies based on the speed with which the trade references respond to our inquiry.

Upon approval your facility's account will be established. Please note our terms require payment within 30 days of the invoice date. Shipping and handling charges are prepaid and added to your invoice. Please do not hesitate to call with any questions at 800-423-2767.

Sincerely,

Customer Service Dept.
Universal Medical Inc.

CREDIT APPLICATION
Universal Medical Inc.
PO Box 1829 Oldsmar FL 34677

Voice: 508-698-6920

order@universalmedicalinc.com

Please include your initial purchase order with application submission. If an order is already pending, please indicate your order reference number here: _____

Company Name _____

Shipping Address: _____

Billing Address _____

City, State, Zip _____

Phone: _____

Invoices will be emailed. Please include the initial invoice submission email address here:

Business Type: _____ Year Established _____

Corporation: Y N

Sales Tax Exempt: Y N

(If yes, please provide a copy of exemption form)

Accounts Payable (contact for payment inquiries)

Contact Name: _____

Title: _____

Email: _____

Phone: _____

Is Payment available by ACH/Direct Deposit: Y

(if yes, please include forms for enrollment. Alternatively we can provide our standard Bank detail form.)

Trade References: Provide the company, account number, contact name, phone number & email address for each reference. Please ensure the listed suppliers provide reference information before listing them. Incomplete applications or applications that do not receive response will not be able to be reviewed.

(1) _____

(2) _____

(3) _____

Bank Reference - All applications must include the following signed "Letter of Release" by an authorized party of your facility. Many references require this release to provide information.

Bank Name: _____

Bank Contact Name: _____

Bank Address: _____

Phone: _____

Email: _____

Incomplete applications can not be reviewed. Please submit completed applications to
order@universalmedicalinc.com

LETTER OF RELEASE

I authorize Universal Medical Inc. to conduct a credit inquiry on our facility for the purpose of establishing credit with their facility. If you have any questions, you may contact me at

_____.

Name: _____

Title: _____

Signature: _____

Facility Name: _____

Phone: _____

Fax: _____

E mail: _____

Date: _____