ADVANCED ORTHO
a new day of healing™

Advanced Orthopaedics, Inc.
326 Main Street
Harleysville, PA 19438
800.270.7074
info@advanced-orthopaedics.com

FAX TO 215-256-9006 - PLEASE PRINT
EMAIL TO info@advanced-orthopaedics.com

Application for Credit

Business Information

Date:

Firm Name _____ ☐ Corporation ☐ Partnership ☐ Sole Proprietorship ☐ LLC

DBA _____ Tax ID _____ DNB# _____

Address _____ Phone _____

City _____ St._____ Zip_____ Fax _____

Owner(s) / Principal(s) _____ Date Business Started _____ Website _____

Purchasing Contact _____ Acct. Payable Contact _____

Email _____ Email _____

Phone _____ Phone _____

Fax _____ Fax _____

Bill To

☐ Same as above

Name _____ Email _____

Attention _____ Phone _____

Address _____ Fax _____

City _____ St._____ Zip _____

☐ Additional Bill To addresses attached

Ship To

☐ Same as above

Name _____ Email _____

Attention _____ Phone _____

Address _____ Fax _____

City _____ St._____ Zip _____

☐ Additional Ship To addresses attached

Tax Information

Is business tax exempt? ☐ No ☐ Yes (If yes, check one of the boxes below)

☐ Product purchased for resale only. Please provide copy of resale certificate.

☐ Charitable or nonprofit organization exempt from sales and/or use tax. Please provide copy of exemption certificate.

☐ Product to be purchased is tax exempt in: Please provide copy of exemption certificate. State _____ County _____

Credit Card for File

Name on Card _____ ☐ VISA ☐ Master Card ☐ AMEX

Expiry Date MM / DD / YYYY _____ CVV Code _____

Business Credit Reference (list minimum three) - If not providing credit card for file

Name _____ Address, City, State, Zip _____ Acct. # _____ (___) Fax. # _____

Name _____ Address, City, State, Zip _____ Acct. # _____ (___) Fax. # _____

Name _____ Address, City, State, Zip _____ Acct. # _____ (___) Fax. # _____

I (we) promise to pay my (our) account in full accordance with the terms stated on each invoice after receipt of goods as specified in terms and conditions. If this account is not paid as agreed, a delinquency charge shall be computed at the rate of 1.5% per month (18% APR) on the unpaid balance. In the Event that it becomes necessary to assign the account for collections, I (we) agree to pay all collection costs and/or if legal action (or appeal) is required, I (we) Agree to pay all attorney fees and costs that are incurred. If suit is brought, venue may be laid in the country and state of the creditor's choice. As principal, I authorize and request creditors and business references to provide information to Advanced Orthopaedics, Inc. required in conjunction with this application. I (we) have read the above terms and conditions and agree to abide by them and Certify that the information given above is complete and accurate.

Executed on this _____ day of _____ , 20 ___ Name of Applicant _____ Signed By _____

Print Authorized Signature _____ Note: This Credit Application must be returned before any products are shipped. Thank You!

For Internal Use Only

Customer Class _____ Referred By _____

Sales Rep _____ Commission ID _____

Terms _____ Customer Acc # _____