PRINT & FAX

Account Setup Application

Customer Information

Existing Customer: ☐ **Acct#:** _____

Full Legal Business Name: _____

Address: _____ **City:** _____

State: _____ **ZIP:** _____ **County:** _____ **Tel#:** _____

County: _____ **Doctor's Name:** _____

DEA Lic#: _____ **State License#:** _____

Contact Email: _____

Shipping Address (If Different From Above)

Address: _____ **City:** _____

State:_____ **ZIP:** _____ **County:**_____

Contact Phone#: _____ **Fax#:** _____

Type Of Business (Check One)

☐ **Individual** ☐ **University** ☐ **Government** ☐ **Corporation**

☐ **Partnership** ☐ **Research Lab** **Other** _____

DEA# _____ **License#**_____

[If applicable copy of DEA Lic must be attached] *[copy of business lic must be attached]*

Tax Exemption or Resale Certificate#:_____

[If applicable copy must be attached

Initial(s) ____ / ____ *Page 1-2*

117 East Huntington Dr. Arcadia, CA 91006 P:(800) 242-4415 Fax:(626) 446-6439

Party or Parties Responsible For Payment

Name: _____Fed Tax ID:_____

Address:_____

City: _____ State: _____ Zip: _____

Day Time Phone:_____ Email address:_____

Statement will be mailed monthly and payment terms will be established based upon your credit history. We accept Visa, Master Card and American Express. Make your checks payable to

Western Medical Supply, Inc.
P.O. Box 660849 Arcadia, CA 91066-0849

All past due invoices will be assessed a monthly finance charge of 1.5% (18% annually). In the event of default, the undersigned agrees to pay all costs of collection including reasonable attorney fees and court costs. If your bank returns any check unpaid, you will be charged a returned check fee of $25.
Applicant authorizes Western Medical Supply, Inc. to obtain a written or oral credit report from any reporting agency in order to establish credit worthiness and limit. Person(s) signing this application, if not an officer for the applicant,acknowledges having the approval to sign and shall be personally or jointly responsible for any payment of the account.

I/We have read this agreement and agree with its terms.

Signature(1):_____**Signature(2):**_____

Print Name(1): _____Print Name(2):_____

Date: _____ **Date: _____**

* *

Western Medical Supply Use Only

Credit Limit: _____ ***By:*** _____ ***Date:***_____

Customer Number : _____ ***Category:*** _____ ***Level:*** _____

Signature:_____

PRINT & FAX

117 East Huntington Dr. Arcadia, CA 91006 P:(800) 242-4415 Fax:(626) 446-6439