

Universal Medical Inc
14 Perry Drive, Unit A
Foxboro, MA 02035
www.universalmedicalinc.com

To whom it may concern:

As your facility is ordering from us for the first time, the following credit application must be completed. Please ensure that all information is completed, incomplete applications may result in a delay in the approval process. If you have already placed an order, please indicate the order reference number in the indicated field. If you have not yet placed your order, you may fax it with your completed credit application. Once you have completed the application, please fax it back to 800-535-6229.

Our accounts receivable department will review the information and contact your bank and trade references. The amount of time required for processing credit applications varies based on the speed with which the bank and 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.

Please remember to include a "letter of release" signed by an authorized staff member so we may process your application.

UNIVERSAL MEDICAL INC.

14 Perry Drive - Unit A

Foxboro, MA 02035

Voice: 508-698-6920

Fax: 508-698-6926

CREDIT APPLICATION

If your facility currently has an order on hold, please indicate your order reference number: _____

Company Name _____

Shipping Address:

Billing Address _____

City, State, Zip _____

Phone: _____

Fax: _____

Type of Business: _____

A/P Contact Name: _____

Year Established: _____

Phone: _____

Corporation: Y N

Fax: _____

E Mail address-

Trade References: Please provide **contact name**, **phone number**, and **e mail** address for your references.

(1) _____

(2) _____

(3) _____

Bank Reference **

Name _____

Address _____

Contact Name: _____

Email Address _____

Account Number: _____

Phone: _____ Fax: _____

**** All applications must include a signed "Letter of Release" by an authorized party of your facility.**

Incomplete applications will not be reviewed.

LETTER OF RELEASE

I, _____, authorize Universal Medical Inc., of
Foxboro, MA 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: _____

Facility Name: _____

Phone: _____

Fax: _____

E mail: _____

Date: _____