Universal Medical Inc.
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, you may fax it with your completed credit application for expedited processing.

Once you have completed the application, please email it to order@universalmedicalinc.com. Alternatively you may fax it to 800-535-6229.

Our accounts receivable department will immediately 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.
Universal Medical Inc.

CREDIT APPLICATION

Universal Medical Inc.
PO Box 1829 Oldsmar FL 34677
Voice: 508-698-6920 **order@universalmedicalinc.com** Fax: 508-698-6926

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

Company Name _____

Billing Address_____

City, State, Zip _____

Phone: _____

Invoices should be: Emailed ☐ US Postal Mailed ☐
If email is preferred please indicate billing email address here:

_____

Business Type: _____ Year Established:_____

Corporation: Y ☐

Sales Tax Exempt: Y ☐

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

Shipping Address:

_____

_____

_____

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, contact name, phone number & email address or fax number for each reference. Please include your account number with the company. Ensure your 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 bank & trade references require this release to provide information.

Bank Name: _____

Bank Address: _____

_____

Bank Contact Name: _____

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:_____