

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 reviewed.

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 credit app submission. If an order is pending, please indicate your order reference number here: _____

Company Name _____

Shipping Address: _____

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 N

Sales Tax Exempt: Y N

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

Accounts Payable (contact for payment Inquiries)

Contact Name: _____

Title: _____

Phone: _____

Email Address: _____

Is Payment available by ACH/Direct Deposit: Y

(if yes, please include forms required to be completed to enroll.
Alternatively we can provide our standard Bank detail form.)

Trade References: Please provide a contact name, phone number & email address or fax number for your reference. Please also include your account number with the company. Ensure that 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 Contact Name: _____

Bank Address: _____

Phone: _____

Email: _____

Incomplete applications will not be reviewed.

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: _____