Cardio Partners Net Term Account Application

Application must be completed and signed to initiate processing.

NAME _____ Parent or Subsidiary of _____

Do you or parent have an existing acct. #: ☐ Yes ☐ No If yes, please provide acct. #: _____

Headquarters Location _____ Are you a distributor: ☐ Yes ☐ No

Billing Address _____

City _____ County _____ State _____ Zip _____

Shipping Address _____

City _____ County _____ State _____ Zip _____

Phone Number w/Area Code: ( ) _____ Fax Number w/Area Code: ( ) _____

Amount of Credit Line Requested: $ _____ Date Business Started: _____

Are Vouchers Required for Payment: ☐ Yes ☐ No If yes, please submit with orders. D & B #: _____

STATE SALES TAX EXEMPT: ☐ Yes ☐ No **If yes, you must provide Cardio Partners with a copy of your completed tax exemption certificate to avoid being charged taxes.**

NAME AND TELEPHONE OF PERSON RESPONSIBLE FOR ACCOUNTS PAYABLE:

Name _____ Phone # _____ Fax # _____ Email: _____

Email for Invoice Delivery if Different Than Above: _____

SHIPPING: Complete Only ☐ Partial Shipment Okay ☐ Are PO's Required ☐ Yes ☐ No

The following persons are authorized to purchase from this account:

1. Name _____ Title _____
2. Name _____ Title _____
3. Name _____ Title _____

REFERENCES (MAJOR SUPPLIERS)

1. Major Supplier Name _____ Account# _____
   Phone Number w/Area Code ( ) _____ Fax Number ( ) _____ Email _____
   Address _____ City _____ State _____ Zip _____
2. Major Supplier Name _____ Account# _____
   Phone Number w/Area Code ( ) _____ Fax Number ( ) _____ Email _____
   Address _____ City _____ State _____ Zip _____
3. Major Supplier Name _____ Account# _____
   Phone Number w/Area Code ( ) _____ Fax Number ( ) _____ Email _____
   Address _____ City _____ State _____ Zip _____

This information is warranted to be true and is given for the purpose of obtaining credit from Cardio Partners. I (we) agree to pay all bills for purchases net 30 days from the date of invoice. Should legal action be instituted to enforce payment of any outstanding balance, I (we) agree to pay all costs of suit and reasonable attorney's fees.

Signature X _____

Print Name & Title _____ Date _____

Please email the completed form to: Credit@Cardiopartners.com

or Fax to: **Toll Free** 844-318-0590
Local 614-760-5330

Payment Remittance Address: Cardio Partners
PO BOX 772834
Detroit, MI 48277-2834

For Internal Use Only

Approved By _____

Date Approved _____ Terms _____ Limit _____