



Return to:
13949 Alvarez Road Suite #100
Jacksonville, FL 32218

Tel: (904) 638-5520 Fax: (904) 638-5522 Att: Sonal Patel

| | | | | | |
|---|--------------------|--------------------------------|---|---------------------|-----|
| Corporate/Business Name: | | Trade Style (D/B/A): | | Date of application | |
| Street Address: | | | City | State | Zip |
| Business is a Subsidiary of/Division of/Owned by: | | | Telephone #: | Fax #: | |
| Type of Business: | Years in Business: | Anticipated Monthly Purchases: | | Opening Order: | |
| A/P Contact Name: | | | A/P Contact Phone Number & FAX NUMBER: | | |
| A/P Email Address: | | | How would A/P like to receive their invoices: <div style="text-align: center;"> EMAIL FAX MAIL </div> | | |

Please List Names & Titles of All Officers:

| <u>First Name</u> | <u>Last Name</u> | <u>Title</u> |
|-------------------|------------------|--------------|
| 1. | | |
| 2. | | |
| 3. | | |

Banking Information:

| <u>Name</u> | <u>Address</u> | <u>Telephone #</u> | <u>Fax #</u> |
|-------------|----------------|--------------------|--------------|
| | | | |

Bank Officer: _____ **Acct. #:** _____

Signature _____ Title _____ Date _____



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Trade References: Please list your three (3) largest suppliers:

| <u>Name</u> | <u>Contact Person</u> | <u>Telephone #</u> | <u>Fax #</u> |
|--------------------|-----------------------|--------------------|--------------|
| 1. Reference Name: | | | |
| Contact Person: | | | |
| Address: | | | |
| Telephone #: | | | |
| Fax #: | | | |
| 2. Reference Name: | | | |
| Contact Person: | | | |
| Address: | | | |
| Telephone #: | | | |
| Fax #: | | | |
| 3. Reference Name: | | | |
| Contact Person: | | | |
| Address: | | | |
| Telephone #: | | | |
| Fax #: | | | |

NOTE: BE SURE TO INCLUDE A COPY OF YOUR RESALE CERTIFICATE

The process takes about 2-5 days depending on how fast your references reply back to us.



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Confidentiality and Trade Reference Authorization

By signing this document you are authorizing Healthcare Supply Solutions, Inc to contact your trade references, and also giving authorization for your Trade Reference to give Healthcare Supply Solutions information requested regarding your account credit history.

Date: _____

Name: _____

Title: _____

Customer Account Number: _____