Account Information Form

Form may be submitted by FAX or EMAIL

6423 Parkland Drive, Sarasota, FL 34243 **Phone:** 941-755-7965 **Fax:** 941-755-6543 **Email:** customerservice@parcusmedical.com

Section I: Contact Information

Company Name: ______________________ **Accounts Payable Contact:** ______________________

Billing Address: ______________________ **Phone:** ______________ Fax: ______________

City: ______________ **State:** ______ **Zip:** ______ **Purchasing Contact:** ______________________

Ship to Address: ______________________ **Phone:** ______________ Fax: ______________

City: ______________ **State:** ______ **Zip:** ______ Email: ______________________

Section II: Business Information

Type of Organization: [ ] Date Established: [ ] Years in Business: ______

Previous Name (if any): ______________________ D & B Number: ______________

Tax Exempt: ☐ No ☐ Yes Tax Exempt Number: [ ] EIN: [ ]

Section III: Owners/Officers Information

Name: ______________________ Title: ______________________

Name: ______________________ Title: ______________________

Section IV: Trade References

Firm Name: ______________________ Phone: ______________ Fax: ______________

Address: ______________________

City: ______________ State: ______ Zip: ______ Account #: ______________________

Firm Name: ______________________ Phone: ______________ Fax: ______________

Address: ______________________

City: ______________ State: ______ Zip: ______ Account #: ______________________

Section V: Authorized User of this account (Only persons listed here will have the ability to purchase on this account).

Name: ______________________ Title: ______________________

Name: ______________________ Title: ______________________

I hereby authorize the above list (Section V) of names as Authorized Account Users for the above listed (Section I) company's commercial charge account. By signing this document I understand that I will be responsible for all charges applied to this account by any of the above named persons. The information given is warranted to be true and Applicant authorizes Grantor to investigate said information. Applicant agrees to pay all collection fees and court costs incurred if it is necessary to seek legal action on the above account.

Name: ______________________

Signature: ______________________ ______________________