

Business Information/Credit Application

ALLEGRO MEDICAL
360 Veterans Parkway, Ste 115
Bolingbrook, IL 60440

MAIN 888-462-5534 – FAX 813-356-0992

Standard Payment Terms: Net 30 Days from Invoice Date
FEDERAL TAX ID #87-0897987

Date: _____

Credit Line Requested (Check one) - \$500 _____, \$1000 _____, \$1500 _____, \$2500 _____, \$5000 or more _____

Business Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone #: _____ Fax #: _____ Email Address: _____

Type of Business (Example – Hospital, Doctor, Chiropractor, School, etc):

Trade References: (Suppliers you have done business with for at least 1 year on credit)

1. Name: _____ Address: _____ Account #: _____

City: _____ State: _____ Zip: _____ Phone #: _____ Fax #: _____

2. Name: _____ Address: _____ Account #: _____

City: _____ State: _____ Zip: _____ Phone #: _____ Fax #: _____

3. Name: _____ Address: _____ Account #: _____

City: _____ State: _____ Zip: _____ Phone #: _____ Fax #: _____

Bank References:

Name: _____ Address: _____

City/St: _____ Zip: _____ Phone #: _____ Fax #: _____ Account #: _____

Firm is a: Proprietorship () Partnership () Corporation () Business Started: _____

State of Incorporation: _____ Date incorporated: _____ Tax-exempt #: _____

(Please include a copy of your resale or sales tax exemption certificate and attach financial statements)

Firm is a: Branch () Division () Subsidiary () Federal ID #: _____

Of Parent Company: _____ Address, City, State: _____

If you belong to a membership group please list name and group number - _____
Proprietors, Partners, Officers:

Name: _____ Home Address: _____

Name: _____ Home Address: _____

The above information is for the purpose of obtaining credit and is warranted to be true. I/We hereby authorize the firm to whom this application is made to investigate the references listed pertaining to my/our financial condition. A copy of this document shall be as the original. Applicant promises to pay for all purchases in accordance with the terms and conditions of the sale as disclosed on Allegro Medical invoices

Application must be signed and dated by an authorized bank account signer/officer of the company.

Signature: _____ Title: _____