

# Dale<sup>®</sup> Medical Products, Inc.

## Distributor Account Application

CredApp Mar10

Contact Name: \_\_\_\_\_ Date: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_

**THIS FORM MUST BE COMPLETELY FILLED OUT IN ORDER TO PROCESS YOUR APPLICATION**

### LEGAL NAME OF BUSINESS

BILL TO ADDRESS CITY STATE ZIP

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PHONE NUMBER FAX NUMBER

YEARS IN BUSINESS # SALES REPS GEOGRAPHIC AREA SERVED BRANCHES EST.ANNUAL

### OWNERS, PRINCIPAL OFFICERS, ETC.

NAME TITLE NAME TITLE

NAME TITLE NAME TITLE

### CREDIT REFERENCES

PRINCIPAL BANK NAME

STREET ADDRESS CITY STATE ZIP

PHONE NUMBER CONTACT NAME

### TRADE REFERENCES (MAJOR MEDICAL MANUFACTURERS)

1. NAME CITY STATE/ZIP PHONE FAX

2. NAME CITY STATE/ZIP PHONE FAX

3. NAME CITY STATE/ZIP PHONE FAX

WHAT OTHER LINES DOES YOUR ACCOUNT DISTRIBUTE:

### SALES BREAKDOWN: THIS SECTION NEEDS TO BE COMPLETED TO PROCESS OUR APPLICATION

\_\_\_\_\_ % IN HOSPITAL SALES \_\_\_\_\_ % IN INTERNATIONAL SALE

\_\_\_\_\_ % IN LABORATORY SALES \_\_\_\_\_ % IN HOME HEALTH SALES

\_\_\_\_\_ % IN PHYSICIAN SALES \_\_\_\_\_ % IN RETAIL SALES

**Minimum order of \$1000.00 required, fax this filled form to 508-695-6587 for distribution consideration.**