Independent Medical Associates

CREDIT APPLICATION

DATE:____________________

COMPANY NAME: ____

COMPLETE ADDRESS: ____

____

CITY STATE ZIP COUNTY

TELEPHONE ________ ____________________________ FAX ________ __________________________

DATE COMPANY FOUNDED ______________ YEARS AT THIS ADDRESS ___________________________

CORPORATION _______ PARTNERSHIP ________ PROPRIETORSHIP______ #OF EMPLOYEES _______

STATE AND DATE OF INCORP. ___________________ MAIN CONTACT ___________________________

NAME OF PRINCIPAL ____

All product will be sent taxable to Florida facilities unless we have a signed Blanket Certificate of Resale or Certificate of Exemption on file.

◇◇

List (4) vendor references you are currently doing business with:

1. COMPANY NAME ____

ADDRESS ____

____

PHONE ________ ______________________________ FAX ________ __________________________

PERSON TO CONTACT __________________________ ACCOUNT # _____________________________

2. COMPANY NAME ____

ADDRESS ____

____

PHONE ________ ______________________________ FAX ________ __________________________

PERSON TO CONTACT __________________________ ACCOUNT # _____________________________

1. COMPANY NAME ______________________________

ADDRESS ______________________________

____

PHONE ________ ______________________ FAX ________ ______________________

PERSON TO CONTACT ______________________ ACCOUNT # ______________________

2. COMPANY NAME ______________________________

ADDRESS ______________________________

____

PHONE ________ ______________________ FAX ________ ______________________

PERSON TO CONTACT ______________________ ACCOUNT # ______________________

◇◇

Bank Reference

NAME ______________________________

ADDRESS ______________________________

____

PHONE ________ ______________________ ACCOUNT # ______________________

BANK OFFICER ______________________________

◇◇

The above statements are submitted for the purpose of obtaining an account with IMA and are true and correct. Applicant expressly authorized IMA to obtain information from the above listed entities concerning it's credit history and authorizes them to release such information:

AUTHORIZED SIGNATURE ______________________ ______________________

PRINT NAME TITLE

______________________ ______________________

SIGNATURE DATE

Please return this form by mail, email or fax:

Independent Medical Associates
Attention: Renauta Rambaran
7301 124th Avenue
Largo, FL 33773
(888) 548-1462
RRambaran@I-MA.com

Any questions regarding this form contact: Renauta at IMA: (888) 548-4462, Ext. 132

IMA
Independent Medical Associates

_____ has recently applied for credit with Independent Medical Associates. We have been requested to provide information concerning our credit history. Therefore, we authorize the investigation of our credit information.

Thank you in advance for your cooperation.

Name: _____

Signature: _____ Date: _____

7301 • 124th Avenue • Largo, FL • 33773 • Phone: 888-548-4462 • Fax: 888-548-1462