

AFTON MEDICAL LLC

2161 FRANCISCO AVENUE, SANTA ROSA, CA 95403
Toll Free: 877-300-6288 / FAX: 877-452-5809

OFFICIAL USE

NEW ACCOUNT INFORMATION

Billing Address:
COMPANY: _____
ADDRESS: _____
CITY, ST, ZIP _____
PHONE: _____
FAX: _____
E-MAIL: _____

Shipping Address:
COMPANY: _____
ADDRESS: _____
CITY, ST, ZIP _____
PHONE: _____
FAX: _____

← Yes Shipping Notification by e-mail

FORM OF BUSINESS: SOLE PROPRIETOR PARTNERSHIP CORPORATION / LLC

STATE SALES TAX RESALE CERTIFICATE # (CA, CT, FL, TX) _____
DUNS # _____ FEIN / SSAN # _____

PROPRIETOR, PARTNERS, CORPORATE OFFICERS

Owner, Partner, President, CEO _____ Phone/Ext: _____
Partner, VP, CFO _____ Phone/Ext: _____
Purchasing _____ Phone/Ext: _____
Accounts Payable _____ Phone/Ext: _____

REFERENCES

Vendor Trade References only

Vendor: _____ Account# _____ Phone: _____ Fax: _____
Vendor: _____ Account# _____ Phone: _____ Fax: _____
Vendor: _____ Account# _____ Phone: _____ Fax: _____
Vendor: _____ Account# _____ Phone: _____ Fax: _____

BANK INFORMATION

Bank: _____ Account # _____
Address _____ Phone: _____
City, St. Zip _____ Fax: _____

I authorize the above listed credit references, including my bank, to release information to Afton Medical LLC. As an authorized representative, I accept the seller's terms and as such am subject to a service charge of 2% per month (24% per annum) on balances exceeding terms. Furthermore, I understand that my orders will not be shipped if my account is past due. I have received a copy of Afton Medical Terms & Conditions polices and agree to abide by them and agree to pay costs and expenses, including attorney's fees i f Afton Medical is forced to consign this account for collections. Accounts referred to collections agree to pay a 35% fee on amount owing.

X _____
Signature of Authorized Representative Print Name Date