APPLICATION FOR CREDIT

(Invoices are due upon receipt)

509 Paul Morris Dr
Englewood, FL 34223
800-373-5935

Date:_____/_____/_____ Account Name:_____

Address: _____City: _____ State: _____ Zip: _____
(Please list additional address on back)

Phone: (_____)_____ Fax: (_____)_____ A/P Contact Name: _____

Years in Business: _____ Federal ID #_____ Email: _____@_____

Business Type: _____Partnership:_____ Corporation:_____ Individual (please check)

PRINCIPAL OWNER/OFFICER

Name: _____ Title: _____

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

Phone Number: _____

BANKING

Name: _____ Address: _____ City: _____

State: _____ Zip: _____ Phone Number: (_____)_____ Contact: _____

CREDIT REFERENCES

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: (_____)_____

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: (_____)_____

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: (_____)_____

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: (_____)_____

Agreement: Applicant agrees to pay invoices to the terms and also agrees to pay finance charges when billed. Interest will be assessed 30 days from date of invoice. Unpaid balances will be subject to an 18% annual finance charge. In the event that any collection action is brought against this account, applicant agrees to pay all costs and reasonable attorney's fees. Applicant authorizes Bank to release information regarding applicant's account (s) to JSB Orthotics & Medical Supply, Inc.

Authorized Signature: _____ Title: _____

Print Name: _____ Date: _____/_____/_____

FAX: 888-875-1229 **EMAIL: Michele@JSBinc.com**