

# PHYSICIAN'S PURCHASING

HELPING DOCTORS MINIMIZE COST SINCE 1998

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## CUSTOMER INFORMATION

Company Name:

Phone:

Fax:

Address:

City:

State:

ZIP Code:

Billing Address:

City:

State:

ZIP Code:

Shipping Address: (Only if different from Billing)

City:

State:

Zip Code:

## BUSINESS INFORMATION

Established Date:

Tax ID #:

Practice Specialty:

Tax Exempt?

**(Circle One)** Sole Proprietorship — Partnership/LLP — LTD. Liability Company — Corporation — Other

Accounts Payable Contact Name:

Email Address:

Phone:

## BANKING INFORMATION

Bank Name:

Address:

City:

State:

ZIP Code:

Phone:

Bank Account #:

Type of Account:

Contact:

## DISTRIBUTOR REFERENCES

Company:

Account #:

Phone:

Company:

Account #:

Phone:

Company:

Account #:

Phone:

## SIGNATURE AND DATE

By signing this application, you are giving Physician's Purchasing permission to act as your purchasing agent. This also gives Physician's Purchasing the ability to sign any non-legally binding paperwork necessary to achieve our goals on your behalf.

Signature:

Date:

EMAIL OR FAX APPLICATION ALONG WITH CURRENT STATE LICENSE AND DEA LICENSE