MEDICAL MART ATLANTIC

Please return to the attention of :MMA REP_____

Fax 902 468-2063 or by Rep e-mail address:_____@medimart.com

CREDIT APPLICATION

Company Name _____

Billing Address _____

_____

Contact Person: _____Email Address_____

Phone: _____ Fax: _____

Shipping Address: _____

_____

Type of Business: _____

Date Established: _____Amount of Credit Requested: _____

Trade References: (Other companies you purchase from)

_____

Name Phone & Fax no.

_____

Name Phone & Fax No.

Bank Reference:
Name and Address of Bank:

_____

_____

Phone No. : _____ Bank Account No : _____
Contact Person:_____

MEDICAL MART ATLANTIC

Medical Mart Supplies Credit Application Page 2…..

Your signature is required to approve the release of credit information to Medical Mart Supplies. We require information on payment trends and credit information for the sole purpose of establishing an account with Medical Mart Supplies.

You may also choose to pay on an ongoing basis by credit card. Visa ____ Master Card ___

American Express ____

Account Number:_____ Exp Date:_____

Your signature is required to show your approval of use of your card for purchases. You may contact Medical Mart to process this under separate cover.

Terr #:_____ Rep: _____ Credit Approved: Credit Denied:

Date:

Medical Mart Supplies LTD. c/o Medical Mart Atlantic
65 John Savage Ave. Dartmouth, Nova Scotia B3B-2C9 [t] 902 468-4087 [f] 902 468-2063