Reset Form

MEDISCA®

CREDIT APPLICATION FORM

▪ Business Information

Company Name: _____

Address: _____

City/State: _____ **Zip Code:** _____

Telephone: _____ **Fax:** _____

Email: _____

A/P Contact Name: _____

A/P Email: _____

Member of a Buying Group: ☐ Yes ☐ No

☐ **I am applying for Blend & Boost credit**

Billing Address: _____

Type of Business: _____

Year Established: _____

Pharmacist License No.: _____

DEA Registration No.: _____

Federal Tax ID No.: _____

NCPDP No.: _____

Credit Request: _____

Sales Tax Certificate ID Number: ***(attach copy)*** _____

▪ Bank Information

Name: _____

Address: _____

City/State: _____

Zip Code: _____

Contact Name: _____

Account No.: _____

Telephone: _____

Fax: _____

▪ Credit Reference Information

Name	Address	Phone	Fax

▪ Payment Method (please choose one of the following)

☐	**Electronic Funds Transfer (EFT) / Direct Deposit** (If selected, we will provide banking information).
☐	**Wire Transfer Cheque** (If selected, we will provide banking information).
☐	**Cheque**
☐	**Credit Card*** (If selected, we will request for credit card information, we accept all major credit cards). ***Please note, no credit card information is to be written on this form.**

In consideration for extension of credit, debtor agrees to (1) Credit Terms of NET 30 DAYS from invoice date, and (2) in the event it becomes necessary for creditor to either bring suit or employ a collection agency to aid in the recovery of any debt owed by the debtor, the creditor shall be entitled to recover, in addition to the amount of debt due, all of its costs and attorneys fees. The signature below authorizes MEDISCA to charge interest on outstanding balances OVER 30 DAYS OLD at rate of 1.0% per month (12% per annum) or to the extent permitted by law.

Signature: _____ **Title:** _____

Name: ***(print)*** _____ **Date:** _____

For Office Use Only

Sales/CS Representative: _____ **Date:** _____

Phone: 1.800.932.1039 / Fax: 1.855.850.5855