WEB-APPLICATION FOR HEALTHCARE PROFESSIONAL

All healthcare professionals are required to complete a application to access specific information and tutorial areas of the web site. If you are a healthcare professional and would also like to order online you should complete the "all-in-one" Healthcare Professional application which includes a Credit Application.

All customers are required to complete a Credit Application and such application approved prior to purchasing online. Upon approval, each customer will be issued a unique ID and password per authorized user.

For orders of drugs or controlled substances, the customer must complete the Controlled Substance Application and receive approval prior to purchasing.

ALL IN ONE HEALTHCARE PROFESSIONAL APPLICATION

Today's Date:______________

[Please complete and return email or by fax to 1 847 267 9078. Thank you]
[If your institution has a standard credit information form, please submit in lieu of this form.]

ABOUT YOU

Legal name: ______________________________________

Address: ____
(Street address required)

____
(P.O. Box, if any)

________________________ ________________
(State) (Zip code)

Telephone: (___) _____ _______ Fax: (___) _____ _______ Email: ____________________

SSN:_____________________ DEA number: ______________________

Specialty: _________________________ Board certifications: ______________________

ABOUT YOUR HOSPITAL/PRACTICE

Legal name of Institution: ______________________________________

Trade name or d/b/a: ____
(State none if not applicable)

Address: ____
(Street address required)

____
(P.O. Box, if any)

________________________ ________________
(State) (Zip code)

Telephone: (___) _____ _______ Fax: (___) _____ _______ Email: ____________________

EIN:_____________________ D & B number: ______________________

Check one: [ ] Corporation [ ] Partnership [ ] Proprietorship [ ] Other (Explain on reverse)

Years in business?:______ Years incorporated?: ______ Employees?: ______ Beds?: ______

ABOUT THE OFFICERS OR PARTNERS

Name	Home Address	SS #
_________________	_________________________________	___________
_________________	_________________________________	___________
_________________	_________________________________	___________
_________________	_________________________________	___________

ABOUT THE BUSINESS

Communities served (List by county and state. Use reverse side if necessary.):

____

____

Primary Community: ____________________ Secondary Community: ____________________

Do you require purchase orders?: [ ] Yes [ ] No; Amount of credit requested?: $___________

Type of payment: Check ______ Wire ______ Credit card: MC____ Visa____ AEX ____

Card number: ________________________ Exp. date: _________

Tax Exempt No.(if applicable):____________________________________

TRADE REFERENCES

Vendor name:____________________________ Contact name: ___________

Address: ____

Telephone: _____________________________ Account Number: _________

High credit:________________ Current balance: ____________________

Vendor name:____________________________ Contact name: ___________

Address: ____

Telephone: _____________________________ Account Number: _________

High credit:________________ Current balance: ____________________

Vendor name:____________________________ Contact name: ___________

Address: ____

Telephone: _____________________________ Account Number: _________

High credit:________________ Current balance: ____________________

Bank name:____________________________ Contact name: _____________

Address: ____

Telephone: _____________________________ Account Number: _________

High credit:________________ Current balance: ____________________

Bank name:____________________________ Contact name: _____________

Address: ____

Telephone: _____________________________ Account Number: _________

High credit:________________ Current balance: ____________________

I, the undersigned, acknowledge all the facts stated in the above application to be true and correct to the best of my knowledge and hereby authorize investigation of all statements contained herein in this application. Furthermore, I acknowledge that my institution has the ability, and is willing to pay its bills on time.

____________________________________ _________________________________
(Authorized signature) (Date signed)

____________________________________ _________________________________
(Print name of Authorized signer) (Title)

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FOR INTERNAL USE ONLY

Recommended by: _______________ [ ] Approved [ ] Denied

Approved:_______________________________ ______________________________

(VP Finance) (Date)