New Customer Application

Distribution Unlimited
Toll Free: (800)716-8888
Office: (623)776-2800
Fax: (623)776-2900

Sales Rep:
Account Type:
Customer ID:

Completed by Distribution Unlimited

Submit via email: Sales@DUMedical.com

Customer Name/ Company: _____ Date: _____

Physician Name: _____

DEA: _____ Medical License: _____ NPI: _____

***Please provide a copy of your DEA Certificate and Medical License*

Shipping Information:

Contact Name/ Company: _____

Address: _____

City: _____ State: _____ Zip: _____

Office Phone: _____ Office Fax: _____

Billing Information: ☐ Check if same as Shipping Information

Contact Name/ Company: _____

Address: _____

City: _____ State: _____ Zip: _____

Accounts Payable Contact Name: _____ Phone: _____

Email Address: _____

***Invoices will be sent to this email address.*

Tax Exempt? ☐ No ☐ Yes #:_____ ***please provide copy of certificate*

Contacts needing access to www.dumedical.com to place orders:

First Name:_____ Last Name:_____ Email Address:_____

First Name:_____ Last Name:_____ Email Address:_____

Authorized Representative (Printed Name/ Title): _____

Signature: _____ Date: _____

PrePay: X	
Net 15:	
Completed by Distribution Unlimited	

Distribution Unlimited
8957 W Windsor Drive, Suite 122
Peoria, Arizona 85305
Phone: (623)776-2800 Fax:(623)776-2900

New Account Payment Information

Please complete form in its entirety and submit to sales@dumedical.com. If requesting Net 15 account provide DUNS#_____ for approval. For questions, please contact Customer Service at (623)776-2800.

BILLING INFORMATION

_____
Company Name

_____
Accounts Payable Manager (Billing Contact)

_____
Email Address

_____
Telephone

_____
Card Holder Name

_____
Billing Address

_____
Billing City, State and Zip Code

Visa MasterCard American Express

_____
Credit Card Number

_____ _____
Expiration Date 3 Digit Security Code
4 Digit for AMEX Cards

I hereby request and authorize Distribution Unlimited to apply payments of all invoices to the credit card listed above on the 1st day invoice becomes past due.

_____
Card holder's Signature

To pay via ACH please contact your sales representative for more information.

Terms- Please Read, Sign and Date the following Statement

In consideration of and in order to induce you to establish an open account line of credit based on the forgoing application, the undersigned promises to pay for monthly purchases in accordance with your terms of sales. If at any time, for any reason, the undersigned is unable to pay for monthly purchases when due, the undersigned agrees to pay and authorizes you to bill my/our account, and any interest computed at the legal rate of 1.5% per month against any past due amount owing on my/our account. In the event it becomes necessary for your company to incur collection costs or institute suit to collect any amount due under this agreement, or any portion thereof, the undersigned promises to pay such additional collection costs, charges and expenses, including reasonable attorney's fees if the account is placed in the hands of any attorney for collection. Furthermore, the undersigned authorizes to charge all outstanding invoices to the signer's credit card on file.

Physician's Signature: _____ Date: _____