



Distribution Unlimited

Toll Free: (800)716-8888

Office: (623)776-2800

Fax: (623)776-2900

New Customer Application

Sales Rep:
Account Type:
Customer ID:

Completed by Distribution Unlimited

Submit via email: Accounts@DUMedical.com

Customer Name/ Company:

Date:

If purchasing Prescription/ Controlled Substances:

Physician Name:

DEA:

NPI:

***Please provide a copy of your DEA Certificate*

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:

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

☐ **Invoice Method** (Please Specify) ☐ Email ☐ Fax ☐ Mail

☐ 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:

**Distribution Unlimited**

8957 W Windsor Drive, Suite 122

Peoria, Arizona 85305

Phone: (623)776-2800 Fax:(623)776-2900

PrePay:**Net 15:***Completed by Distribution Unlimited*

New Account Payment Information

Please complete form in its entirety and submit to accounts@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

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**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 against any past due amount owing on my/our account in the event. In the event it becomes necessary for your company to incur collection costs or institute suite 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: _____