QuadMed, Inc.

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CUSTOMER CREDIT APPLICATION

BUSINESS CONTACT INFORMATION

Agency Name:			
Billing Address:			
City:		State:	Zip Code:
Are Purchase Orders Required ?	Exempt from Sales Tax ?	If yes, Tax Exemption #	
Billing Contact Person:		Title:	
Phone:	Fax:	Email:	
Date business commenced:			
Sole proprietorship:	Partnership:	Corporation:	Other:
Shipping Address:			
City:		State:	ZIP Code:
The following person(s) are authorized to purchase from this account:			
Name:	Title:		
Name:	Title:		
Name:	Title:		
Purchasing Contact Person:	Title:		
Telephone:	Fax:	E-mail:	

BUSINESS AND CREDIT INFORMATION

Bank name:		
Bank address:	Phone:	
City:	State:	ZIP Code:
Type of account (Check all that apply)	**List Account Number(s) Below:**	
Savings ☐		
Checking ☐		
Other ☐		

BUSINESS/TRADE REFERENCES – MUST HAVE RECENT ACTIVITY / WITHIN PAST 12 MONTHS

Company name:		**Type of Account:**	
Address:	City:	State:	ZIP Code:
Phone:	Fax:	E-mail:	
Company name:		**Type of Account:**	
Address:	City:	State:	ZIP Code:
Phone:	Fax:	E-mail:	
Company name:		**Type of Account:**	
Address:	City:	State:	ZIP Code:
Phone:	Fax:	E-mail:	

AGREEMENT

1. All invoices are to be paid **30 days** from the date of the invoice.
2. Claims arising from invoices must be made within **ten (10)** working days.
3. Refer to our Catalog's General Information page for other pertinent information regarding Terms.
4. By submitting this application, I authorize QuadMed, Inc. to make inquiries into my banking and business/trade references.

SIGNATURES

Signature: Title: Date:	Signature: Title: Date: