

CREDIT APPLICATION

DATE				
COMPANY NAME				
COMPLETE ADDRESS				
CITY	STATE	ZIP	COU	NTY
TELEPHONE	FAX			
DATE COMPANY FOUNDED_	YEA	RS AT THIS A	ADDRESS _	
CORPORATIONPART	NERSHIP	PROPRIET	ORSHIP	#OF EMPLOYEES
STATE AND DATE OF INCORP.	MAIN CONTACT			
NAME OF PRINCIPAL				
All products will be sent taxable to of Exemption on file.) Florida facilities unle	ess we have a s	signed Blanke	et Certificate of Resale or Certificate
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List (4) vendor references you are	currently doing busine	ess with:		
1. COMPANY NAME				
ADDRESS				
PHONE				
PERSON TO CONTACT		ACCOUNT #		
2. COMPANY NAME				
ADDRESS				
PHONE_				
PERSON TO CONTACT		ACCOUNT#		

3. COMPANY NAME		
ADDRESS		
PHONE		FAX
PERSON TO CONTACT		ACCOUNT#
4. COMPANY NAME		
ADDRESS		
PHONE		FAX
PERSON TO CONTACT		ACCOUNT#
PHONE	ACCOUNT #	
BANK OFFICER		
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IMA to obtain information from the abo	ove listed entities concerning its credit	ith IMA and are true and correct. Applicant expressly authorized history and authorizes them to release such information. By your ices within 30 days of the invoice date from IMA:
AUTHORIZED SIGNATURE		
	PRINT NAME	TITLE
_	SIGNATURE	DATE

Please return this form by mail, email or fax:

Independent Medical Associates (*IMA*)
Attention: Sue Ramsay
7301 124th Avenue
Largo, FL 33773
(888) 548-1462 FAX
(888) 548-4462 Ext. 132 PHONE