Independent Medical Associates

CREDIT APPLICATION

DATE:____________________

COMPANY NAME: ____

COMPLETE ADDRESS: ____

____

CITY STATE ZIP COUNTY

TELEPHONE ________ ____________________ FAX ________ ____________________

DATE COMPANY FOUNDED ____________ YEARS AT THIS ADDRESS ____________________

CORPORATION ________ PARTNERSHIP ________ PROPRIETORSHIP______ #OF EMPLOYEES ________

STATE AND DATE OF INCORP. ____________________ MAIN CONTACT ____________________

NAME OF PRINCIPAL ____

All product will be sent taxable to Florida facilities unless we have a signed Blanket Certificate of Resale or Certificate of Exemption on file.

List (4) vendor references you are currently doing business with:

1. COMPANY NAME ____

ADDRESS ____

____

PHONE ________ ____________________ FAX ________ ____________________

PERSON TO CONTACT ____________________ ACCOUNT # ____________________

2. COMPANY NAME ____

ADDRESS ____

____

PHONE ________ ____________________ FAX ________ ____________________

PERSON TO CONTACT ____________________ ACCOUNT # ____________________

1. COMPANY NAME ____________________

ADDRESS ____________________

____

PHONE ________ ____________________ FAX ________ ____________________

PERSON TO CONTACT ____________________ ACCOUNT # ____________________

2. COMPANY NAME ____________________

ADDRESS ____________________

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PHONE ________ ____________________ FAX ________ ____________________

PERSON TO CONTACT ____________________ ACCOUNT # ____________________

Bank Reference

NAME ____________________

ADDRESS ____________________

____

PHONE ________ ____________________ ACCOUNT # ____________________

BANK OFFICER ____________________

The above statements are submitted for the purpose of obtaining an account with IMA and are true and correct. Applicant expressly authorized IMA to obtain information from the above listed entities concerning it's credit history and authorizes them to release such information:

AUTHORIZED SIGNATURE ____________________ ____________________

PRINT NAME TITLE

____________________ ____________________

SIGNATURE DATE

Please return this form by mail, email or fax:

Independent Medical Associates
Attention: Sue Ramsay
11733 66th Street North
Suite 113
Largo, FL 33773
(888) 548-1462
SRamsay@I-MA.com

Any questions regarding this form contact: Sue at IMA: (888) 548-4462, Ext. 132