



CREDIT APPLICATION

A Division of Philips Healthcare
555 N. Commerce St., Aurora, IL 60504 USA
Tel: (800) 238-3780 (USA & CANADA)
Tel: (630) 585-2100 Fax: (630) 585-2125

Dunlee – Arlington Facility
2312 Avenue J., Arlington, TX 76006 USA
Tel: (800) 544-9729 (USA & CANADA)
Fax: (817)640-6644

Company Name: _____ Date: _____
Address: _____ City: _____ State: _____
(Physical street address required)
Country: _____ Postal/Zip Code: _____ Company Website: _____
Phone Number: _____ Fax Number: _____ Email: _____
Contact Name: _____ Title: _____ Federal Tax #: _____
Type of Business: _____ Years in Business: _____ Tax Exempt Cert. #: _____
D-U-N-S Number (Dun & Bradstreet): _____

Note: Please include copies of all applicable Reseller Certificates when you return this completed form.

LIST OF COMPANY DIRECTORS:

Name: _____	Title: _____	Years w/ Company: _____
Name: _____	Title: _____	Years w/ Company: _____
Name: _____	Title: _____	Years w/ Company: _____
Name: _____	Title: _____	Years w/ Company: _____

Have you ever purchased from Dunlee in the past? Yes No
If yes, what was your company's name and address at the time? Same Other _____

SERVICE BASE:

Hospitals _____ (>300 beds) Hospitals _____ (<300 beds) Imaging Centers _____ Clinics _____

EQUIPMENT SERVICED:

BY TYPE: CT % _____ Special Procedures % _____ Mammo % _____ X-Ray % _____ Image Intensifiers % _____

BY MANUFACTURER: *(please list)* _____

ESTIMATED QUANTITY OF PRODUCTS REPLACED PER YEAR:

CT _____ Special Procedures _____ Mammo _____ X-Ray _____ Image Intensifiers _____

CURRENT PRODUCT SUPPLIERS: _____

EQUIPMENT MANUFACTURERS REPRESENTED: _____

TO WHICH COUNTRIES DO YOU SHIP PRODUCTS? _____

PREFERRED METHOD OF SHIPMENT:

United States Shipments: FOB Destination Ship on customer account (customer responsible for insurance)
International Shipments: Use freight forwarder arranged by Dunlee Use customer's freight forwarder

For internal use only:
Customer Type: New Existing
Customer Number: _____
Date Created: _____
CC: _____

Freight Information
Name: _____
Contact Name: _____
Phone: _____



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Company Name: _____

I/We authorize Dunlee to investigate our credit history, bank references, audited financial statements, management reports and any information deemed necessary to extend credit.

I/We do hereby agree jointly and individually: 1) to pay for all goods, wares and merchandise supplied to me or any of us or the above business; and 2) to pay for all housing deposits charged to me or to any of us or to the above business resulting from failure to return housings within 30 days of invoice date unless otherwise stated against the return authorization number supplied with the shipment. In the event that the account is placed with a third party collection, I/We agree to pay all costs including reasonable attorney fees and court costs.

Per FDA 21 CFR and EN ISO 13485, all records of installation of X-Ray/CT tubes must be maintained by the company or institution performing the installation. Your signature below guarantees that record keeping will be maintained. If purchased products are to be exported or re-exported, I/We agree to follow and abide by all U.S. export regulations that apply at the time of shipment.

I/WE AGREE THAT ANY AND ALL PURCHASES MADE BY ME/US FROM DUNLEE SHALL BE GOVERNED BY DUNLEE'S STANDARD TERMS AND CONDITIONS OF SALE, AS AMENDED FROM TIME TO TIME AT THE SOLE DISCRETION OF DUNLEE. I/WE HEREBY ACKNOWLEDGE THAT, AS PART OF THE DUNLEE APPLICATION PROCESS, I/WE HAVE RECEIVED A COPY OF AND HAVE REVIEWED DUNLEE'S STANDARD TERMS AND CONDITIONS OF SALE AND AGREE TO BE BOUND BY SUCH TERMS AND CONDITIONS.

Authorized Signature: _____ Date: _____
Name: _____ Title: _____

Bank name: _____ Account #: _____
Savings Checking

Other, please specify: _____ Phone #: _____ Fax #: _____

CREDIT REFERENCES: (please complete this section only if you are applying for credit with Dunlee)

1) _____ Account #: _____
_____ Phone #: _____
Contact : _____ Fax #: _____

2) _____ Account #: _____
_____ Phone #: _____
Contact : _____ Fax #: _____

3) _____ Account #: _____
_____ Phone #: _____
Contact : _____ Fax #: _____

<i>For internal use only:</i>			
Regional Sales Manager	_____ PG _____	Open Line of Credit Requested	_____
Authorization to Process Credit Application	_____ (Inside Sales Manager)	Date	_____
Customer #	_____ Credit Limit Granted _____	Date	_____
Approval of Credit Limit	_____ (Credit Manager)	Date	_____
Philips PROTECT Screening Results	_____		