James Coffer
Accounts Receivable
615-620-8521
1-855-868-2034 Fax
allpartsmedical.accounting@Philips.com

Dear valued customer,

Thank you for considering AllParts Medical as your source for medical imaging parts. Regarding the attached documents, I would like to make two suggestions which normally make this process proceed more quickly:

First, please provide as much information as possible. Especially with the banking information, this reduces delays in getting a response.

Second, if you have a personal contact at your references, please provide their contact information. Sending requests to a specific person who is willing to walk the paperwork through almost always provides a faster reply than a general email or fax number.

Again, thank you for your business and I hope we can have a very fruitful relationship.

James Coffer

Accounts Receivables/Credit Risk Specialist

Internal Use Only	
Date Received:	Reviewed by:
Approved by:	

Please submit a valid resell certificate or tax exempt form, or your purchases will be subject to sales tax.

CREDIT APPLICATION FOR A BUSINESS ACCOUNT

BUSINESS CONTACT INFORMATION			
Title:			
Company name:			
Phone:	Fax:	E-mail:	
Registered company address:			
City:		State:	ZIP Code:
Date business commenced:			
Sole proprietorship:	Partnership:	Corporation:	Other:

BUSINESS AND CREDIT INFORMATION			
Primary business address:			
City:		State:	ZIP Code:
How long at current address?			
Telephone:	Fax:	E-mail:	

ACCOUNT PAYABLE INFORMATION	
AP CONTACT:	PHONE NUMBER:
EMAIL ADDRESS:	ADDRESS:

TRADE REFERENCES			
Company name:			
Address:			
City:		State:	ZIP Code:
Phone:	Fax:	E-mail:	
Company name:			
Address:			
City:		State:	ZIP Code:
Phone:	Fax:	E-mail:	
Company name:			
Address:			
City:		State:	ZIP Code:
Phone:	Fax:	E-mail:	
Company name:			
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 seven working days.
3. By submitting this application, you authorize AllParts Medical, LLC/Philips to make inquiries into the business/trade references that you have supplied.

SIGNATURES	
Title: Date:	Title: Date:

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1-855-868-2034 Fax
allpartsmedical.accounting@Philips.com

Date:

To:

Thank you for choosing AllParts Medical for your source for medical imaging parts. We will be happy to consider you for credit terms, but require additional information.

Bank: _____

Account No. _____

Bank Address: _____

City: _____ State: _____ ZIP code: _____

Phone or FAX No. _____

By signing and submitting this document, you authorize AllParts Medical, LLC/Philips to request information from the above named financial institution for purposes of determining eligibility for credit terms. Any information received will be held in the strictest confidence.

Signature: _____ Date: _____

Thank you in advance for your attention to this request. Upon completion, please fax back to 855-868-2034. You can also email a response to:
Allpartsmedical.accounting@Philips.com