

Health Management Systems, Corp. - Credit Application

Billing Information:

Company Name: _____
A/P Contact Name: _____
Address: _____

City: _____ State: _____ Zip: _____
Phone: _____
Fax: _____
Email: _____

Shipping Information: If same as billing check here ____ and move to next section.

Company Name: _____
Receiving Contact Name: _____
Address: _____

City: _____ State: _____ Zip: _____
Phone: _____
Fax: _____
Email: _____

Trade References: If opening a pay by credit card account check here ____ and move to next section.

Supplier 1: _____
Phone #: _____
Contact: _____
Address: _____
Account #: _____

Supplier 2: _____
Phone #: _____
Contact: _____
Address: _____
Account #: _____

Supplier 3: _____
Phone #: _____
Contact: _____
Address: _____
Account #: _____

Other Information:

Company Website: _____

Purchasing Contact:
Name: _____
Phone: _____
Email: _____

Purchase Order Required: Yes No

Special Invoice Requirements: _____

Persons Authorized to charge on Account: _____

Tax Exempt: Yes No (if yes, please fax tax exempt certificate to (972) 578-9854)

Legal Structure: Corporation LLC LLP Partnership Sole Proprietor Non-Profit
Date of Incorporation: _____ State: _____

Federal Tax ID #: _____ Duns#: _____
In Business Since: _____ Type of Business: _____