



BARRINGTON DIAGNOSTICS BARRINGTON VENTURES MEDICAL BARRINGTON REGULATORY CONSULTING BARRINGTON RESPIRATORY

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bvmedical.com

CREDIT APPLICATION AND AGREEMENT

Firm Name \_\_\_\_\_ Tel (\_\_\_\_) \_\_\_\_\_ Fax (\_\_\_\_) \_\_\_\_\_

Billing Address \_\_\_\_\_

Business Address (if different from above) \_\_\_\_\_

Type of Business \_\_\_\_\_

Ownership: (\_\_\_\_) Proprietorship (\_\_\_\_) Partnership (\_\_\_\_) Corporation

Year Established \_\_\_\_\_ At Present Location since (date) \_\_\_\_\_

Sales Tax Exemption # \_\_\_\_\_ Amount of Anticipated Annual Purchases \_\_\_\_\_

List All Principle(s), Partners(s), and Corporate Officer(s)
(This information must be filled out so that credit can be established.)

Name \_\_\_\_\_ Title \_\_\_\_\_ Name \_\_\_\_\_ Title \_\_\_\_\_

Address \_\_\_\_\_ Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

SS# \_\_\_\_\_ Tel (\_\_\_\_) \_\_\_\_\_ SS# \_\_\_\_\_ Tel (\_\_\_\_) \_\_\_\_\_

Trade and Bank Reference

(Please provide at least 3 current accounts and 1 bank account.)

Company Name \_\_\_\_\_

Address \_\_\_\_\_

Tel (\_\_\_\_) \_\_\_\_\_ Fax (\_\_\_\_) \_\_\_\_\_

Account # \_\_\_\_\_ Contact \_\_\_\_\_

Company Name \_\_\_\_\_

Address \_\_\_\_\_

Tel (\_\_\_\_) \_\_\_\_\_ Fax (\_\_\_\_) \_\_\_\_\_

Account # \_\_\_\_\_ Contact \_\_\_\_\_

Company Name \_\_\_\_\_

Address \_\_\_\_\_

Tel (\_\_\_\_) \_\_\_\_\_ Fax (\_\_\_\_) \_\_\_\_\_

Account # \_\_\_\_\_ Contact \_\_\_\_\_

Bank Name \_\_\_\_\_

Address \_\_\_\_\_

Tel (\_\_\_\_) \_\_\_\_\_ Fax (\_\_\_\_) \_\_\_\_\_

Account # \_\_\_\_\_ Contact \_\_\_\_\_

Open account invoices are due 30 days from the invoice date, unless otherwise noted. BV Medical reserves the right to change the 30 day term to cash if account is past due.

The signature below authorizes BV Medical to verify the above given information, and confirms your agreement to abide by the Terms and Conditions on the following page and BV Medical's credit terms.

Applicant (Print or type name) \_\_\_\_\_ Date \_\_\_\_\_

Signature \_\_\_\_\_ Title \_\_\_\_\_

# Terms and Conditions

## Orders:

Once placed indicates a single purchase to be shipped at one time to one destination and will be processed within 48 hours from the time of order. Additions or revisions are considered new orders and may cause delays in the delivery schedule. Free freight for any order of \$1,250 or more shipped to one location within Continental U.S. (Certain products excluded.) **Placement of an order signifies knowledge and acceptance of all terms and warranties.**

## Payment Terms:

**Customers within Continental US:** Terms are Net 30 days after credit approval, Prepaid, or Credit Card<sup>1</sup>. An unpaid invoice is considered late if not received within 30 days from invoice date. A service charge of 1-1/2% per month will be charged on all overdue accounts.

**International Customers:** Prepayment by Bank Check, Bank Wire, Credit Card<sup>1</sup>

BV Medical will not accept any claims for products that have been damaged during shipping. For your protection, should visual inspection upon receipt of merchandise reveal loss or damage, it must be noted on the freight bill signed by the carrier's agent. The carrier will furnish the consignee with the necessary form for filing a claim. It is suggested you check with the carrier regarding its claim process.

## Return Policy:

No material shall be returned without BV Medical's prior permission and a Return of Goods Authorization Number (RA#). This will only be issued after purchaser supplies the correct invoice number and date, or customer's purchase order number covering original shipment. All returns must be shipped freight prepaid to BV Medical in Lake Barrington, Illinois. Items will only be accepted for credit if returned within sixty (60) days from original date of purchase, provided the goods are still in new condition. There will be a 25% handling and restocking fee.

**Personal Guarantee:** For consideration of the extension of credit, I hereby personally guarantee payment of all charges made in connection with this account. I waive any requirement that BV Medical, notify me of default by the buyer. This shall be a continuing personal guarantee and shall not be affected by any modifications to this agreement with or without my consent.

**Applicant's Statement:** In the event my/our company defaults payment of bill and is turned over for collections my/our company shall be fully liable for any fees and sums charged by the collection agency or attorney. If any suit or other judicial proceeding is instituted or is collected through probate or bankruptcy proceeding, my/our company will be fully liable for all attorney fees and court costs incurred by BV Medical the collection of said bills.

Personal Signature \_\_\_\_\_ Date \_\_\_\_\_

Printed Name \_\_\_\_\_ Social Security # \_\_\_\_\_

Address \_\_\_\_\_

Drivers License # \_\_\_\_\_

Own  Rent  Married\*  Single

<sup>1</sup> Credit Card payments are subject to approval and acceptance by BV Medical

All prices and specifications are subject to change by BV Medical without notice