WOLF MEDICAL SUPPLY, INC.
13951 NW 8th Street
Sunrise, FL 33325
954.835.2300 Phone 954.835.0301 Fax

NEW ACCOUNT CREDIT APPLICATION

Please fax this form with a copy of your pharmacy license to 954.835.0301 at your earliest convenience

Date: ____________ Pharmacy (or Physician) License #: ____________

Company Name: ____________

Bill To: ____________

____

Ship To: ____________

____

Phone: ____________ Fax: ____________

Type of Business: (Sole Owner, Partnership, Corp.) ____________ Date of Incorporation: ____________

Florida Annual Resale Certificate No.(if applicable please fax a copy): ____________

Purchasing Contact: ____________

Purchasing E-Mail: ____________ Phone: ____________

A/P Contact: ____________ A/P Phone: ____________

A/P E-Mail: ____________ A/P Fax: ____________

Bank: ____________ City, State: ____________

Bank Phone: ____________ Bank Fax: ____________ Primary Acct# : ____________

Bank Phone: ____________ Bank Fax: ____________ Secondary Acct #: ____________

I authorize Wolf Medical Supply, Inc. to verify the status of our corporate bank account and to obtain information pertaining to our application for a line of credit with Wolf Medical Supply, Inc. All information supplied will be kept in strict confidence.

Authorized Signature: ____________ **Title:** ____________

Printed Name: ____________ **Date:** ____________

Trade References: In order to consider your application we must receive 3 trade references, please provide us with at least 6 trade references as some companies do not offer credit references.
(Please include Co. Name, Account No., Phone and Fax Number)

	Co Name	Acct No.	Phone No.	Fax No.
1)				
2)				
3)				
4)				
5)				
6)				