



DEALER CREDIT APPLICATION

Future Mobility Healthcare Inc. Dealer Credit Application Form

OWNERSHIP

Company Name		Email:	
Business Name:		Phone:	
Ship to Address:		City:	
Fax:		Province:	
Contact:		Postal Code:	P.O.#
Bill to Address:		City:	
Fax:		Province:	
Phone:		Postal Code:	

OWNERSHIP

Corporation: _____ Partnership: _____ Proprietorship: _____

Principle Owners or Stockholders:

NAME & TITLE:	
ADDRESS:	
NAME & TITLE:	
ADDRESS:	
NAME & TITLE:	
ADDRESS:	

PURCHASING INFORMATION

We will be using a _____ Standing PO# _____ Contact # _____ Contact Name: _____

FINANCIAL INFORMATION - BANK

NAME: _____

ADDRESS: _____ SIGNATURE: _____

PHONE: _____

ACCT#: _____ TITLE: _____

NOTE: Please sign here authorizing your bank to release information on your account.

TRADE INFORMATION – Please provide (3) complete references including account numbers.

COMPANY & CONTACT:		
ADDRESS:		
TEL:	EXT:	FAX:
COMPANY & CONTACT:		
ADDRESS:		
TEL:	EXT:	FAX:
COMPANY & CONTACT:		
ADDRESS:		
TEL:	EXT:	FAX:

_____ Credit Amount Requested

_____ Check here if COD sales are acceptable until credit is approved.

Note: If account is approved to purchase on open account, all purchases will be billed on Net 30 terms, unless otherwise stated. The company or persons applying with this form certify that all the information is correct and that they understand FUTURE MOBILITY HEALTHCARE INC reserves the right to withdraw credit privileges at anytime.

DATE: _____ SIGNATURE: _____

TITLE: _____ PRINT NAME: _____

CREDIT DEPARTMENT USE

References checked by: _____ Credit Limit \$: _____

Credit Approved by: _____ **Date Approved:** _____