Account Application

Thank you very much for your interest in our products and services. We look forward to assisting you with your requirements and strive to provide quality and value to your organization.

As part of our process to provide additional payment options for your account we ask you that you complete the attached two pages Account and Credit Applications.

Please be sure to fill the application completely, if you are Non-Taxable please provide a signed copy of the Tax exempt certificate for your Institution. We must have a signed copy in our files in order not to collect Sales Tax in Certain States.

Also, please send copy of business license.

Your requested line of credit allows for our staff to estimate your monthly requirements and we'll do our best to try to meet your required limit, if your requirements exceed the limit that's available for your account we will work with you and will provide additional payment options for a portion of your requirements during the month.

If you have any questions please feel free to contact our Finance Department at (714) 529-2027 ext. 1552

Thank you!

Account Application

Date Received: _____

COMPANY PROFILE:

Business Name_____ Other DBA used:_____

Address: _____

Phone #:_____ Fax#: _____

Shipping Address_____

Email Address_____

Type of Business: _____ Date Established: _____ How long in Business:_____

Federal Tax ID#: _____ Resale Certificate# _____

Does State, County, or City require a License? Yes ☐ No ☐ If Yes, License #_____

Medical Device License (please attached a copy if needed): _____

Mortgage holder/Landlord _____

OWNERSHIP: ☐ Sole Proprietorship ☐ Partnership ☐ Corporation

PRINCIPAL: _____
(NAME) (Title) (SS#)

PRINCIPAL: _____
(NAME) (Title) (SS#)

PRINCIPAL: _____
(NAME) (Title) (SS#)

PRINCIPAL: _____
(NAME) (Title) (SS#)

TRADE REFERENCES:

NAME	ADDRESS/PHONE#
_____	_____
_____	_____
_____	_____
_____	_____

BANK REFERENCES:

(Name)	(Address)	(Acct #)	(Contact)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

No. of Employees _____ Est. Annual sales _____ Sales Area_____

DISCLAIMER: The Applicant warrants that all information furnished herein, whether on this form or on separate listing as noted, is true. complete, and correct in all material aspects. The Applicant hereby authorizes WestPrime to conduct inquiries necessary in order to grant credit based on the information contained herein or on separate lists as noted. WestPrime Healthcare is committed to protecting your privacy. All information provided on this form shall be kept strictly confidential and used solely for credit review purposes.

REV: 20150618

Credit Line Application

Line of Credit Requested $_____

Has the firm or any of its principals ever been Bankrupt? Yes No

If Yes, explain_____

Any misrepresentation in this application will be considered evidence of fraud, since this information is the basis for the extending of credit. As an inducement to grant credit, the undersigned warrants that the information submitted is true and correct. You are authorized to investigate the credit references and principals listed.

In consideration for the extension of credit, said business promises to pay for all purchases within the terms agreed and agrees to pay a service charge per month of 1-1/2% per month (18% annual percentage rate) on all past due balances. In the event any third parties are employed to collect any outstanding monies owed by said business the undersigned agrees to pay reasonable collection costs, including attorney fees, whether or not litigation has commenced, and all costs of litigation incurred. The undersigned represents that he/she has the authority to execute this credit agreement on behalf of the business identified. I hereby acknowledge the above listed terms and conditions of sale and understand that additional terms and conditions may apply. For complete and updated terms and conditions, visit www.westprimehealthcare.com/termsandconditions.sc

_____
(Name of Business)

_____ _____ _____
(Print Name) (Title) (Signature)

_____ _____ _____
(Print Name) (Title) (Signature)

Personal Guarantee

In consideration for Westprime Healthcare (Div. Westprime Systems, Inc.) extending credit to the business identified below for any materials and/or services after this date at the request of applicants or its agents, the undersigned individual hereby personally guarantees unconditionally and irrevocably the prompt payment of any sums now or hereafter owed to Westprime Healthcare (Div. Westprime Systems, Inc.) by the business identified below whether said sums are due under open account, contract or otherwise.

It is understood and agreed that credit, if extended, is to be on a continuing basis and may exceed estimated maximum credit limit required as stated in the credit agreement between _____ and the business. Westprime Healthcare (Div. Westprime Systems, Inc.) shall not be obligated to notify the undersigned of the dates or amounts of any such credit and the undersigned waive demand, notice of default and any extension of time or any other forbearance which may be extended by the creditor.

This guaranty shall continue in force until notice in writing, sent by registered or certified mail, return receipt requested is received by _____. Said notice shall specify the date on which this guaranty is to be terminated; said date not to be less than seven days after such notice is received. Such termination shall in no way release the undersigned as to any sum or debt incurred prior to such termination.

Date_____ Name:_____
(Name of person guaranteeing payment, NO TITLE)

Home address_____

Home Phone #_____ SS#_____

Signature of person guaranteeing payment_____

Name of Business whose account is guaranteed_____

CREDIT DEPARTMENT USE ONLY

Date:_____

Line of Credit: Approved /Denied Amount Approved $: _____

Comments:_____

Terms:_____ Freight:_____

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REV: 20150618

CREDIT CARD TRANSACTION AUTHORIZATION FORM

Account Information

Carholder's Name: _____

(Name as it appears on the credit card)

Authorized Card Users: _____

Credit Card Type: __ MasterCard __ Visa __ American Express __ Discover

(✓ Credit Card Type)

Credit Card Number: _____ Valid Thru: ____ / ____

(Month / Year)

CVV: _____ (3 digit number located on the back of your credit card – appears on the front for AMEX)

Billing Address: _____

(Address) (City) (State) (Zip)

Transaction Amount: $ _____ (U.S. Currency) *Transaction Total: $ _____

Payment Authorization

I hereby authorize WestPrime Systems, Inc. (WestPrime Healthcare) to charge the above listed credit card for the herein listed Transaction Total amount. I agree to pay said amount according to the card issuer agreement:

Cardholder's Signature: _____ Date: _____

Thank you for your order – We appreciate your business!

We accept all major credit cards.

*A 2.93% Credit Card Convenience Fee will be added to this transaction.

YES ☐ NO ☐

PLEASE CHECK YES OR NO IF OK TO STORE CREDIT CARD INFORMATION ON FILE.

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