



## DEALER CREDIT APPLICATION

Please type or print legibly. All sections must be completed entirely. Attach any additional pertinent information or schedules.

### BUSINESS INFORMATION

Legal name of business/company:

Month/Year business started:

Parent company:

Legal form:  Corporation  Sole proprietorship  General Partnership  Individual  LLC  Other:

\*(US) Federal tax ID#:

(CA) GST#:

(CA) PST#:

(CA) HST#:

**\* For US dealers, please attach your Sale and Resale Certificate with this credit application form.**

Buying group affiliation:  Yes  No

Name of Buying Group:

**Billing/mailling address:**

City:

Prov./State:

Postal/Zip Code:

Country:

Phone:

Fax:

Website address:

**Corporate/Parent address** (If different from billing address):

City:

Prov./State:

Postal/Zip Code:

Country:

Phone:

Fax:

Line(s) of business:  DME  HME  Full Line Dealer  Homecare  Internet sales  Rehab  Repair  
(Select all that apply)  Nursing Home/Hospital  Wholesaler  Other (Please specify):

Have you ever filed for bankruptcy?  Yes  No

AMYLIOR product interest:

Power wheelchairs  Seating  Walking Aids  Scooters  Manual Wheelchairs  Batteries  Aftermarket  
 Spare Parts  Other:

### SHIPPING INFORMATION

**Please indicate type of loading/unloading configuration for each location.**

SHIPPING LOCATION #1<sup>Ⓢ</sup>  Loading dock  Forklift  Other (Please specify):

Address: (If different from billing address)

City:

Prov./State:

Postal/Zip Code:

Phone:

Fax:

SHIPPING LOCATION #2<sup>Ⓢ</sup>  Loading dock  Forklift  Other (Please specify):

Address:

City:

Prov./State:

Postal/Zip Code:

Phone:

Fax:

Ⓢ If more than two shipping locations, please attach a list of addresses and loading/unloading configuration.

### COMPANY PRINCIPALS

OFFICERS, OWNER(S) AND/OR PARTNERS (CEO, CFO, A/P, ETC.)

Name:

Title:

Name:

Title:

Name:

Title:

Number of sales reps (ATPs):

Number of employees:

### TRADE REFERENCES

Supplier name

Account number.

Telephone number

Fax number



## DEALER CREDIT APPLICATION (continued)

## CONTACT MASTER FILE

1. Contact name:		Title:
Phone:	Ext.:	Email address:
Fax:	Website:	
Primary duties/Department: <input type="checkbox"/> Executive/Owner <input type="checkbox"/> A/P <input type="checkbox"/> Customer Service <input type="checkbox"/> Technical Support <input type="checkbox"/> Dealer Sales (ATP) (Please X appropriate box) <input type="checkbox"/> Purchasing <input type="checkbox"/> Physiotherapist <input type="checkbox"/> Occupational Therapist <input type="checkbox"/> Other: _____		
Business address, City, Province/State, Postal/Zip Code:		

2. Contact name:		Title:
Phone:	Ext.:	Email address:
Fax:	Website:	
Primary duties/Department: <input type="checkbox"/> Executive/Owner <input type="checkbox"/> A/P <input type="checkbox"/> Customer Service <input type="checkbox"/> Technical Support <input type="checkbox"/> Dealer Sales (ATP) (Please X appropriate box) <input type="checkbox"/> Purchasing <input type="checkbox"/> Physiotherapist <input type="checkbox"/> Occupational Therapist <input type="checkbox"/> Other: _____		
Business address, City, Province/State, Postal/Zip Code:		

3. Contact name:		Title:
Phone:	Ext.:	Email address:
Fax:	Website:	
Primary duties/Department: <input type="checkbox"/> Executive/Owner <input type="checkbox"/> A/P <input type="checkbox"/> Customer Service <input type="checkbox"/> Technical Support <input type="checkbox"/> Dealer Sales (ATP) (Please X appropriate box) <input type="checkbox"/> Purchasing <input type="checkbox"/> Physiotherapist <input type="checkbox"/> Occupational Therapist <input type="checkbox"/> Other: _____		
Business address, City, Province/State, Postal/Zip Code:		

4. Contact name:		Title:
Phone:	Ext.:	Email address:
Fax:	Website:	
Primary duties/Department: <input type="checkbox"/> Executive/Owner <input type="checkbox"/> A/P <input type="checkbox"/> Customer Service <input type="checkbox"/> Technical Support <input type="checkbox"/> Dealer Sales (ATP) (Please X appropriate box) <input type="checkbox"/> Purchasing <input type="checkbox"/> Physiotherapist <input type="checkbox"/> Occupational Therapist <input type="checkbox"/> Other: _____		
Business address, City, Province/State, Postal/Zip Code:		

5. Contact name:		Title:
Phone:	Ext.:	Email address:
Fax:	Website:	
Primary duties/Department: <input type="checkbox"/> Executive/Owner <input type="checkbox"/> A/P <input type="checkbox"/> Customer Service <input type="checkbox"/> Technical Support <input type="checkbox"/> Dealer Sales (ATP) (Please X appropriate box) <input type="checkbox"/> Purchasing <input type="checkbox"/> Physiotherapist <input type="checkbox"/> Occupational Therapist <input type="checkbox"/> Other: _____		
Business address, City, Province/State, Postal/Zip Code:		



## DEALER CREDIT APPLICATION (continued)

### BANK REFERENCES

Bank name and branch	Telephone.	Bank manager	Account number (s)

\*\*\*\*\* The following section must be completed \*\*\*\*\*

### PURCHASING INFORMATION

Based on **Amylior product interest** selected on page 1, what manufacturers are you currently purchasing from, and why?


What percentage of your business is dedicated to these products?

Average monthly sales: \$

Estimated yearly sales: \$

Estimated monthly orders from AMYLIOR

Number of units:

Dealership overview information:


### FINANCIAL INFORMATION

Estimated average monthly purchases from AMYLIOR over the next 12 months: \$

If credit requirements are expected to exceed \$50,000, please submit a copy of your last annual financial statement or your most recent tax return.

Applicant's name:

Application date:

### TERMS & CONDITIONS

#### CONDITIONS UNDER WHICH CREDIT ACCOUNT IS GRANTED:

1. Dealer shall conduct business with AMYLIOR as well as its customers in a fair and ethical manner.
2. Dealer agrees to provide support for AMYLIOR products in pre-sales promotions, direct customer support and after sale follow-up service when necessary. This includes product warranty service.
3. Dealer is required to keep his account in good standing within the terms agreed upon.
4. Minimum annual purchases of 10,000 \$ dealer net are required to retain dealer credit account status.
5. Dealer must comply with all rules and regulations set forth by AMYLIOR, in any documents governing AMYLIOR'S business with its customers.
6. Conditions subject to change at AMYLIOR discretion with written notice.

#### BY SIGNING THIS APPLICATION FOR CREDIT, DEALER UNDERSTANDS AND AGREES TO THE FOLLOWING:

- If an open line of credit is approved, Dealer understands that Dealer will be assigned trade credit terms. Dealer agrees to pay account within these terms.
- Dealer understands that AMYLIOR reserves the right to hold orders prior to release for production as well as any pending shipments, if invoices are not paid within terms.
- Dealer understands that AMYLIOR has the right to discontinue secondary discounts allowed (if any), if credit terms and/or minimum order requirements are not met.

Dealer signature:

Date:

Print name:

Title:

### ▼ FOR INTERNAL USE ONLY ▼

Credit department approval:

Account number:

Date:

Approved discount:

Approved terms:

Sales approval for discount and terms:

Date: