



Dear Credit Applicant:

Thank you for choosing Healthcare Signs, Inc. for your interior sign solutions.

Since you have requested open terms with us, please complete the attached credit application. In completing the application, please follow the five suggestions below to assist us in providing you with a quick and accurate response:

- Answer every question—put N/A if a question doesn't apply.
- For your bank reference, provide a correct contact name, telephone number, and fax number. As a rule, we will contact this reference **by fax first**.
- Indicate if you are affiliated with any other company and, if so, provide the information requested.
- Sign the application—if you are able to attach a digital signature, please do so and submit electronically. If not, please print out your completed credit application, sign, and fax to us. Without your signature, the bank may refuse to give us a credit reference - thereby delaying our response to you.
- If you are a reseller and believe you are not required to pay applicable sales tax(es), please fax a copy of the applicable resale certificate. Otherwise, we may be required to collect sales or use tax from you.
- If you reside in Tennessee and are tax-exempt for any reason, please fax a copy of the applicable tax-exempt certificate.

Please be aware—the more information you can provide to us about your company, the quicker we can respond and the more likely we can approve your request for credit. The information you provide: 1) is solely for the purpose of establishing an open account with our company, 2) will be treated with strict confidentiality, and 3) will not be shared with any third party.

UNLESS OTHERWISE REQUESTED, THE INITIAL CREDIT LIMIT FOR ALL CUSTOMERS WILL BE \$500, BASED UPON A LIMITED CREDIT CHECK. FOR ALL CUSTOMERS REQUESTING A CREDIT LIMIT GREATER THAN \$500, A COMPLETE CREDIT EVALUATION WILL BE PERFORMED. IN ADDITION, FOR CUSTOM ORDERS GREATER THAN \$500, A 50% DEPOSIT IS TYPICALLY REQUIRED.

Upon completion, please fax the signed credit application (and any other material) to:

Fax #: (423) 698-2864
Attn: Credit Manager

Thank you for choosing Healthcare Signs, Inc.

Sincerely,

David Valentine
Controller / Finance Manager

CREDIT APPLICATION

BILLING ADDRESS

Company Name _____
Address _____
City _____ State _____ ZIP _____
Contact _____
Phone _____ Fax _____
A/P Contact _____
A/P Phone _____ A/P Fax _____

SHIPPING ADDRESS

Company Name _____
Address _____
City _____ State _____ ZIP _____
Contact _____
Phone _____ Fax _____
DUNS # _____

Principal Officers _____

Type of Business

- Proprietorship Corporation
 Partnership Other _____

Year Established _____

Payment to be made in name of _____

Credit Limit Requested* _____

* \$500 unless otherwise noted

Are you affiliated with another company? Yes No

Company Name _____

Address _____

City _____ State _____ ZIP _____

Phone _____ Fax _____

PO required _____

Order Pending Yes No

Tax Exempt* Yes No

* Tennessee only. If yes, please include tax exempt certification.

BANKING HISTORY

Bank Name _____

Address _____

City _____ State _____ ZIP _____

May we contact your bank? Yes No

Account # _____

Contact _____

Phone _____ Fax _____

CREDIT REFERENCES

1) Company Name _____

Address _____

City _____ State _____ ZIP _____

Contact _____

Phone _____ Fax _____

2) Company Name _____

Address _____

City _____ State _____ ZIP _____

Contact _____

Phone _____ Fax _____

All credit applications are accepted on the basis of the applicant complying with our credit terms, which are NET 30 DAYS FROM DATE OF INVOICE. Accounts with a past due status will have all new orders placed on credit hold until the account is brought to a current status. Applicant is liable for any reasonable collection and/or attorney fees incurred, should it be necessary to place the account for collection. We the undersigned understand, acknowledge, and accept the above terms of sale. We further certify that the information given herein is true and correct. This signature serves as authorization for Healthcare Signs, Inc. to verify the listed credit references and for the bank and trade references listed above to release financial and credit information to Healthcare Signs, Inc. concerning our account.

Authorized Signature _____

Date _____

Print Name _____

Email Address _____



HEALTHCARE SIGNS, INC.

OFFICE USE ONLY

Sent By: _____