20 STRATHEARN AVE., UNIT 3
BRAMPTON, ONTARIO L6T 4P7

TOLL FREE: 1-866-RAYMAX1
PHONE: 1-905-791-3020
FAX: 1-905-791-3375
EMAIL: SALES@RAYMAXMEDICAL.COM
WWW.RAYMAXMEDICAL.COM

DEALER AND CREDIT APPLICATION FORM

DATE:________________________

SECTION A: (GENERAL INFORMATION)

COMPANY NAME:____________________________OPERATING STATE/PROVINCE:_____________

ADDRESS:____UNIT/SUITE:_______

CITY:_____________________PROVINCE/STATE:_______________ZIP/POSTAL CODE:________

TELEPHONE:__________________FAX: ___________________EMAIL:______________________

BRIEF DESCRIPTION OF BUSINESS:____

____

____

SECTION B: (FINANCIAL INFORMATION/REFERENCES)

BANK NAME:____

ADDRESS:____

BANK CONTACT PERSON:_____________________TELEPHONE:__________________EXT._______

TRADE REFERENCES:

1) ____TELEPHONE:_______________

2) ____TELEPHONE:_______________

3) ____TELEPHONE:_______________

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SECTION C: (SALES/CAPABILITIES)

SALES VOLUME FOR MOST RECENT YEAR-END:____

EXPECTED SALES FOR CURRENT YEAR-END:____

NUMBER OF EMPLOYEES AT PRESENT TIME:____

NUMBER OF SERVICE TECHNICIANS AT PRESENT TIME:__________________________________

TYPE OF TEST EQUIPMENT USED & METHOD OF ASSURING COMPLIANCE WITH F.D.A.

STANDARDS:____

SECTION D: (CORPORATION INFORMATION)

NAME OF CORPORATION OFFICERS (NAME 3)

NAME:____TITLE:____________________

NAME:____TITLE:____________________

NAME:____TITLE:____________________

SECTION E: (AGREEMENT)

CREDIT REQUIRED:____

THE ABOVE INFORMATION IS HEREWITH SUBMITTED TO RAYMAX MEDICAL CORP. FOR THE PURPOSE OF CREDIT APPLICATION ONLY.

I AGREE TO FILL IN, SIGN AND RETURN ALL TEST RESULT FORMS, ENCLOSED WITH EVERY SYSTEM AT THE TIME OF INSTALLATION TO COMPLY WITH F.D.A REGULATIONS.

SIGNED:____

TITLE:____