Account Application

Application must be completed and signed, with order attached, to initiate processing.

NAME _____ Parent or Subsidiary of _____

Do you or parent have an existing acct. #: ☐ Yes ☐ No If yes, please provide acct. #: _____

Headquarters Location _____ Are you a distributor: ☐ Yes ☐ No

Billing Address _____

City _____ County _____ State _____ Zip _____

Shipping Address _____

City _____ County _____ State _____ Zip _____

Telephone Number: ( ) _____ Fax Number: ( ) _____

Amount of Credit Line Requested: $ _____ Date Business Started: _____

Are Vouchers Required for Payment: ☐ Yes ☐ No If yes, please submit with orders. D & B #: _____

STATE SALES TAX EXEMPT: ☐ Yes ☐ No If yes, you must provide MedFire Innovations with a copy of your tax exemption certificate to avoid being charged taxes.

SHIPPING: Complete Only ☐ Partial Shipment Okay ☐ Are PO's Required ☐ Yes ☐ No

The following persons are authorized to purchase from this account:

1. Name _____ Title _____
2. Name _____ Title _____
3. Name _____ Title _____

NAME AND TELEPHONE OF PERSON RESPONSIBLE FOR ACCOUNTS PAYABLE:

Name _____ Phone # _____ Fax # _____ Email: _____

BANK REFERENCE:

Bank _____ Bank Contact Name _____

Address _____ City _____ State _____ Zip _____

Phone ( ) _____ ACCOUNT NUMBER (REQUIRED) _____

AUTHORIZATION TO RELEASE BANK INFORMATION

This is my authorization to the Bank to release information to MedFire Innovations Inc., for the purpose of evaluating our application for credit.

Authorized Bank Signature X _____ Date _____

REFERENCES (MAJOR SUPPLIERS)

1. Major Supplier Name _____ Account# _____
   Telephone Number w/Area Code ( ) _____ Fax Number ( ) _____
2. Major Supplier Name _____ Account# _____
   Telephone Number w/Area Code ( ) _____ Fax Number ( ) _____
3. Major Supplier Name _____ Account# _____
   Telephone Number w/Area Code ( ) _____ Fax Number ( ) _____

This information is warranted to be true and is given for the purpose of obtaining credit from MedFire Innovations, Inc. I (we) agree to pay all bills for purchases net 30 days from the date of invoice. Should legal action be instituted to enforce payment of any outstanding balance, I (we) agree to pay all costs of suit and reasonable attorney's fees.

Signature X _____

Print Name & Title _____ Date _____

Please mail the completed form to:
MedFire Innovations, Inc.
2425 Camino Del Rio South, suite #125
San Diego, CA 92108

Payment Remittance Address:
MedFire Innovations, Inc.
2425 Camino Del Rio South, suite #125
San Diego, CA 92108