



Specialty Pharmaceutical Distribution Credit application

Please print or type.

Section 1 | General Information

Business Name _____

Business Address _____

City _____ State _____ Zip Code _____ County _____

Phone Number () _____ Fax Number () _____

Section 2 | Financial Information

Type of Ownership *(please check one)*

Proprietorship Partnership Corporation Limited Liability Company State of Incorporation _____

Legal Partnership or Corporate Name of Business _____

Federal Tax I.D. # _____ State I.D. # _____

This number must correspond with an attached sales tax exemption certificate.

Shipping Address _____

City _____ State _____ Zip Code _____ County _____

Phone Number () _____ Fax Number () _____

Affiliated Businesses *(please include address)* _____

Please list the names and titles of all Proprietors, Partners and Corporate Officers. *(please attach additional sheets if necessary)*

Name _____ Title _____ % Owned _____ Social Security # _____

Name _____ Title _____ % Owned _____ Social Security # _____

Name _____ Title _____ % Owned _____ Social Security # _____

Primary Business Contact _____ Title _____

Primary Purchasing Contact _____ Title _____

Number of years in business _____ Number of years in business under present ownership _____

Please list your major Suppliers and/or existing Wholesalers.

Supplier _____ Address _____ Phone _____ Fax _____

Contact _____ Account # _____ High Credit _____ Amount Owed _____

Supplier _____ Address _____ Phone _____ Fax _____

Contact _____ Account # _____ High Credit _____ Amount Owed _____

Please list your Financial Institutions.

Bank _____ Contact _____ Account # _____

Address _____ Phone _____ Fax _____

