

BUSINESS CONTACT INFORMATION

Title: _____ Company Name: _____

Phone: _____ Fax: _____ E-mail: _____

Registered Company Address: _____

City: _____ State: _____ ZIP Code: _____

Date Business Commenced: _____

Sole Proprietorship: _____ Partnership: _____ Corporation: _____ Other: _____

BUSINESS AND CREDIT INFORMATION

Primary Business Address: _____

City: _____ State: _____ ZIP Code: _____

How long at current address? _____

Phone: _____ Fax: _____ E-mail: _____

Bank Name: _____ Bank Address: _____

Phone: _____ City: _____ State: _____ ZIP Code: _____

Type of Account: Checking _____ Savings: _____ Other: _____

Account Number: _____

BUSINESS/TRADE REFERENCES

Company Name: _____

Address: _____ City: _____ State: _____ ZIP Code: _____

Phone: _____ Fax: _____ Email: _____

Account Number: _____

Company Name: _____

Address: _____ City: _____ State: _____ ZIP Code: _____

Phone: _____ Fax: _____ Email: _____

Account Number: _____

Company Name: _____

Address: _____ City: _____ State: _____ ZIP Code: _____

Phone: _____ Fax: _____ Email: _____

Account Number: _____

TERMS OF AGREEMENT

- 1.) All invoices are to be paid 30 days from the date of the invoice
- 2.) Claims arising from invoices must be made within 7 business days.
- 3.) By submitting this application, you authorize MDS Associates Inc. to make inquiries into the banking and business/trade references that you have supplied.

SIGNATURES

X _____

X _____

Title: _____ Date: _____

Title: _____ Date: _____