Approved by:	
Credit Limit Amount:	
Account Number:	
Date Approved:	

New Customer Application

Company Name:_____Date:_____

Billing Address:_____

City:_____State:_____ Zip_____

Main Telephone Number:_____Main Fax Number:_____

Company Email Address:_____

Shipping Name:_____

Shipping Address:_____

City:_____State:_____ Zip_____

Web Address:_____

Buyer Name:_____

Buyer Phone Number:_____ Email:_____

SSN or FED ID Number:_____

We are subject to Sales Tax: YES / NO (exemption certificate must be attached and list items for which you are exempt to receive exemption)

Accounts Payable Contact Name:_____

Accounts Payable Contact Number:_____Email:_____

Please circle one: Proprietorship Partnership Corporation LLC Other_____

Type of Business:_____Date Business Started:_____

Credit Limit Requested:_____

Do you require purchase orders? Yes / No

President/Owner:_____

Phone Number:_____ Fax Number:_____

Address:_____City:_____State:_____Zip:_____

Bank Reference Name:_____Contact Name:_____

Account Number:_____

Bank Phone Number:_____ Bank Fax Number:_____

Please list three Trade references:

Name:_____

Phone Number:_____Fax Number:_____

Address:_____City:_____State:_____Zip:_____

Name:_____

Phone Number:_____Fax Number:_____

Address:_____City:_____State:_____Zip:_____

Name:_____

Phone Number:_____Fax Number:_____

Address:_____City:_____State:_____Zip:_____

SIGNATURE REQUIRED TO PROCESS ORDERS

Signature of Officer, Partner or Owner:_____

Print Name:_____

Title:_____ Date:_____

By signing above, the Company acknowledges that the terms of payment are Net 30 days.

PLEASE SEND COMPLETED APPLICATION VIA FAX TO 405-728-1301 ATT: LAUREN
or EMAIL TO LAUREN@APEXMEDICALGAS.COM