|  |  |  |  |  |
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| **Ship To/Bill To: 425 Enterprise Ave Wauseon, OH 43567**  **Telephone:** 800 541 3213 **www.WheelChairCarrier.com**  **CREDIT APPLICATION** | | | | |
| **BUSINESS INFORMATION** | | | | |
| Company Name (include DBA): | | | | |
| Phone: Fax: Accounts Payable Contact: | | | | |
| Company Address: | | | | |
| City: | | | State: | ZIP Code: |
| Date Business Commenced: | | | Tax ID# | Email: |
| Company Web Address: | | | | |
| Sole Proprietorship: Partnership: Corporation: Other: | | | | |
| **BANK REFERENCE** | | | | |
| Bank Name: | | | | |
| Bank Address: | | Phone: | | |
| City: | | State: ZIP Code: | | |
| Type of Account(s) | Account Number(s) | | | |
| Savings |  | | | |
| Checking |  | | | |
| **BUSINESS/TRADE REFERENCES** | | | | |
| Company Name: | | | | |
| Address: | | | | |
| City: | | State: ZIP Code: | | |
| Phone: Fax: | | Account Number: | | |
| Company Name: | | | | |
| Address: | | | | |
| City: | | State: ZIP Code: | | |
| Phone: Fax: | | Account Number: | | |
| Company Name: | | | | |
| Address: | | | | |
| City: | | State: ZIP Code: | | |
| Phone: Fax: | | Account Number: | | |
| **AGREEMENT** | | | | |
| 1. All invoices are to be paid 30 days from the date of the invoice. 2. By submitting this application, you authorize LAMAT, LLC / WheelChair Carrier to make inquiries into the banking and business/trade references listed above to release appropriate business and/or personal credit information. Additionally, you warrant that the information you have provided on this application is true, correct, and complete. | | | | |
| **SIGNATURES** | | | | |
| Title:  Date: | | | Title:  Date: | |