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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.
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| **SIGNATURES**  |
| Title: Date:  | Title: Date:  |