



Office Use Only

- Approved
- Declined
- Deferred

Initials: _____

Date: ___/___/___ Account #: _____
Limit: \$ _____ Sales Rep: _____

Dealer Credit Application

COMPANY INFORMATION

Type of Organization:

- Partnership
- Proprietorship
- Corporation

Date Established: ___/___/___
MM / DD / YY

Legal Name: _____

Operating As: _____

Subsidiaries / Divisions: _____

Principals & Positions: _____

Provincial Sales Tax No.: _____

(Please provide copy of certificate)

Estimated monthly credit amount required: \$ _____

Billing Address: _____

City: _____ Province: _____ Postal Code: _____

Tel: _____ Fax: _____ Email: _____

A/P Contact: _____ Purchasing Contact: _____

Shipping Address: _____

City: _____ Province: _____ Postal Code: _____

BANKING INFORMATION

Bank Name: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Tel: _____ Fax: _____ Email: _____

Account No: _____ Account Manager: _____

Please read and complete all information requested in this Credit Application form. Incomplete applications cannot be processed, and will result in unnecessary delays in evaluating and granting credit. Submit your completed application by Fax to the number below, and mail the original to the address below. Once your application has been received and reviewed, you will be contacted by our Customer Service Representatives to complete the process. Please allow 1-2 weeks for processing. All information provided is of a confidential nature, and will be used for the sole purpose of evaluating and granting credit terms to the applicant.

D Y N A M I C H E A L T H C A R E S O L U T I O N S .

325 Healey Rd, Unit 4 Bolton On, L7E 5C1

Phone: 1-866-875-2877 ~ (905) 951-8541 Fax: 1-866-875-2878 ~ (905) 951-7785

info@dynamichcs.com ~ www.dynamichcs.com

TRADE REFERENCES (3 Required)

Company Name: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Tel: _____ Fax: _____ Email: _____

Contact Name / Position: _____ Account No: _____

Company Name: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Tel: _____ Fax: _____ Email: _____

Contact Name / Position: _____ Account No: _____

Company Name: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Tel: _____ Fax: _____ Email: _____

Contact Name / Position: _____ Account No: _____

LIST ALL AUTHORIZED PURCHASERS

Name: _____ Title: _____

Name: _____ Title: _____

Name: _____ Title: _____

PAYMENT TERMS

Opening Order and until credit is approved.

COD/CIA

Balance Due (from date of invoice)

Net 30 days

Full Credit Hold

at 60 days

Prepayment Required for Future Orders

at 90 days

Automatic Collection Process (full cost plus 2% interest monthly charged to your credit card)

at 120 days

Credit Card number _____ Expiry Date _____

Cardholders name _____ Visa or MasterCard (Please circle which)

I, the undersigned have read, and agree to comply with the policies and payment terms of **Dynamic Health Care Solutions**, as outlined in this Application for Credit. I hereby authorize you to obtain any information required to evaluate our credit, from the above and/or other sources, as you deem appropriate.

Name: _____ Signature: _____
 (Please print name of a Signing Officer)

Position: _____ Date: _____

Name: _____ Signature: _____
 (Please print name of a Signing Officer)

Position: _____ Date: _____