BANYAN HEALTHCARE

toll free 800 836.4408
cell 561 445.2886
fax 561 852.7410

www.banyanhealthcare.com

Please complete this application legibly in BLUE or BLACK ink. Fax it to 561-852-7410.

1. Company Information

Company Name: D.B.A.:

Address: City: State: ZIP:

Phone: ( ) Fax: ( )

Website: DUNS Number:

Tax Exempt or Resale Number (Please include copy of certificate):

Type or Category of Business:

Number of Years in Business: Number of Employees:

Please provide contact information for the party completing this application:

Name: Title:

Direct Phone: ( ) Email:

2. Business Arrangement

Is the company incorporated? ❑ Yes ❑ No Number of Years:
Is the company a partnership? ❑ Yes ❑ No Number of Years:

Please provide the contact information for (2) OFFICERS (if a corporation) or (2) PARTNERS (if a partnership)

Officer / Partner (1)

Name:

Title:

Direct Phone: ( )

Email:

Officer / Partner (2)

Name:

Title:

Direct Phone: ( )

Email:

3. Credit Background

Primary Bank Name:

Routing Number: Checking Account Number:

Savings Account Number:

Phone: ( ) Fax: ( )

Banyan Healthcare REQUIRES initial purchases are processed via CREDIT CARD
Banyan Healthcare RESERVES THE RIGHT to charge overdue balances to credit cards

Business Name On Credit Card:

Individual Name On Credit Card:

Type of Credit Card: ❑ VISA ❑ AMEX ❑ MasterCard ❑ Discover Other:

Number: Expiration Date:

Billing Address:

Billing City: State: ZIP:

Please provide the information regarding your average monthly purchases and accounts receivable:

Average monthly purchases: $ Current accounts receivable: $

4. Trade References – Banyan Healthcare REQUIRES (3) Trade References

Reference 1

Contact Name:
Account Number:
Number of Years Associated:
Direct Phone: ( ) - -
Fax: ( ) - -
email:

Reference 2

Contact Name:
Account Number:
Number of Years Associated:
Direct Phone: ( ) - -
Fax: ( ) - -
email:

Reference 3

Contact Name:
Account Number:
Number of Years Associated:
Direct Phone: ( ) - -
Fax: ( ) - -
email:

Account Agreement and Terms of Sale

Consent for Application and Credit Verification
The undersigned hereby applies to Banyan Healthcare for credit. It is understood and agreed upon that the undersigned specifically consents to Banyan Healthcare investigating the applicant's credit history which may include the use of "Third Party" commercial and / or consumer credit reports for the purpose of extending credit.

Pricing
Prices are subject to change without notice. The most recent price list supersedes previously published price lists.

Shipping Arrangements
All merchandise is shipped via United Parcel Service ("UPS") "Ground" unless specified otherwise. UPS charges will be added to your bill. Shipments outside of the continental United States will be billed accordingly. UPS requires an appropriate destination (NO P.O. BOXES) with an available signature provider, if needed.

Billing Terms and Delinquent Account Policies
Banyan Healthcare extends the following terms: Net balance due (30) days from the invoice date. A 1% discount may be taken if payment is received within 10 days of invoice date. A finance charge of 2% will be charged monthly on outstanding balances (30) days past the invoice date. Orders will not be shipped on delinquent accounts. Banyan Healthcare reserves the right to terminate open account credit at anytime. If default of payment occurs, the customer agrees to pay any and all attorney's fees.

Returns – Defective, Damaged, or Erroneously Shipped Merchandise – Requirements:
Notifications of defective, damaged, or erroneously shipped merchandise must be made within (7) days of receipt. All shipping charges for the returned merchandise will be incurred by the customer. A "Return Merchandise Authorization" (RMA) number will be provided by Banyan Healthcare Customer Service. Replacement of or credit for the merchandise will be issued after the product is returned and inspected by Banyan Healthcare.

Returns – All Other Merchandise – Requirements:
Credit will be issued on resalable merchandise:

- Returned within (30) days of invoice date: full credit.
- Returned after (31) days of invoice date: full credit minus 20% restocking / processing fee.
- Returned after (60) days of invoice date: please call Customer Service.

I understand that the Account Agreement and Terms of Sale policies may change at any time, and that I will be notified of such changes by US mail.

Signature Requirements:
Corporation: (2) CORPORATE OFFICERS' signatures required.
Partnership: (2) PARTNERS' signatures required.

Signature: _____ Date: ____ / ____ / ____

Name: _____ Title: _____

Signature: _____ Date: ____ / ____ / ____

Name: _____ Title: _____

Personal Guarantee
In consideration of credit granted by Banyan Healthcare, the undersigned PERSONALLY guarantees any and all charges and / or money due to Banyan Healthcare will be paid, the sum to include any and all attorney's fees. In the event payment is demanded by Banyan Healthcare, the undersigned agrees to make payment within (30) days. This personal guarantee covers any and all unpaid debts above and beyond the business line of credit. The personal guarantee applies to all monies above the business credit limit.

Signature Requirements:
Corporation: (2) CORPORATE OFFICERS' signatures required.
Partnership: (2) PARTNERS' signatures required.

Signature: _____ Date: ____ / ____ / ____

Name: _____ Title: _____

Social Security Number: ____ ____ ____ ____ ____ ____ ____ ____ ____

Signature: _____ Date: ____ / ____ / ____

Name: _____ Title: _____

Social Security Number: ____ ____ ____ ____ ____ ____ ____ ____ ____