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WHOLESALE CREDIT APPLICATION

LEGAL NAME & ADDRESS FOR BILLING (Please type or print)

Name: _____

Street: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____ Email: _____

SHIP-TO INFORMATION (IF APPL)

Name: _____

Street: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

OWNERSHIP (circle one):

Sole Proprietorship: Owner's Name _____

Partnership: Partners names _____

Corporation: President: _____

Vice Pres.: _____

Treasurer: _____

FEDERAL TAX ID# _____

ACCT. PAYABLE CONTACT/PHONE#: _____

PAYMENT TERMS: PREPAYING FOR ORDERS NET 30 DAY CREDIT TERMS

COMMERCIAL REFERENCES (Required if you are requesting Credit Terms, Please provide name, address, phone # & acct #.)

1. _____

2. _____

3. _____

I agree to abide by the policies set forth above and in the terms & conditions provided by Aleva Health. I understand that once an account has been established, my opening order will ship with Net 30 Terms, or prepayment (upon my request.) I understand that Aleva Health will not pull any credit reports or contact any commercial references unless I have requested Credit Terms, as indicated above. If credit terms have been requested, I authorize Aleva Health to check the credit references I have provided above and to pull credit reports on any/all individuals or companies listed above to certify that the information provided above is complete and accurate. I authorize Aleva Health to process any past due balances exceeding 45 days to the credit card provided below if credit terms have been approved. If I have requested prepayment, I authorize all orders be charged to the credit card listed below. I understand that my failure to abide by these terms will result in the termination of my credit with Aleva Health. I also agree to be personally responsible for payment of any outstanding and past due balances.

Officer Signature: _____ Date: _____

Name of Officer (please print): _____ Position: _____

Credit Card for balances exceeding 45 days: Type (circle): VISA MC AMEX DISC

CC#: _____ Exp: _____

NAME ON CARD: _____

BILLING ADDRESS: _____