Supreme MEDICAL
1-800•461•1370

P.O. BOX 850247
MOBILE, AL 36685
TEL 251.660.6000 FAX 800.461.1277
WWW.SUPREMEMEDICAL.COM

BUSINESS ACCOUNT APPLICATION

1	**Company Information**		
A	Business Name		
B	Legal Status		(LLC, Corporation, Partnership, Sole Proprietor)
C	Bill-To Address		
D	Ship-To Address	☐ Same as Bill-To | Drop Shipping to Patients' Homes? ☐ Yes ☐ No *(if you have multiple ship-to addresses, please attach in separate document w/ application)*	
E	Purchasing Contact		
F	Purchasing Phone#		
G	Purchasing Email	☐ E-mail Confirmations	
H	Payables Contact		
I	Payables Phone#		
J	Payables Fax#		
K	Payables Email	☐ E-mail Invoices	
L	Federal Tax ID #		State of Incorporation:
M	Annual Revenue	$	Years in Business:
N	Estimated Supreme Monthly Purchases	$	
O	Online Ordering	Would you like to be setup for Online Ordering? ☐ Yes ☐ No	

2	**Owners Information**		
A	Name:	Title:	Own _____%
B	Name:	Title:	Own _____%
C	Name:	Title:	Own _____%

Credit Card used for Product Purchases? ☐ Yes ☐ No

If yes, skip sections 3 and 4 and complete the Credit Card Authorization (page 3) with your application in lieu of this.

3	**Credit References - Minimum of 3 references required for credit consideration**				
	Company Name	Contact Person	Phone#	Fax#	Account#
A					
B					
C					
D					
4	**Bank References**				
	Bank Name	Contact Person	Phone#	Fax#	Account#
A					
B					

Thank you for your interest in doing business with Supreme Medical. Please print and complete this form.
FAX TO: (251) 660-7533

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AUTHORIZATION TO PURCHASE AND MAKE CREDIT INQUIRY

The undersigned is authorized to make purchases and grants permission of Supreme Medical Fulfillment Systems, Inc. (hereafter referred to as Supreme Medical) to make inquiry on financial, credit and related matters to applicant's financial institution(s), lending firm(s) and references listed elsewhere on this application and they are hereby authorized to give you any information their files contain.

Under penalties of perjury, I swear or affirm that the information provided is true and correct as to every material matter. I authorize release of information to Supreme Medical by the references above. I have read and agree to the Terms and Conditions as listed on page 4.

LIABILITY FOR COLLECTION FEES AND COSTS

The undersigned agrees to pay any and all collection costs if this account is referred for collection, or if suit is brought to collect this account. Further it is agreed that the undersigned will pay all costs and reasonable attorney's fees incurred on any appeal to the appellate court. Supreme Medical retains a security interest in all goods sold until the full Supreme Medical purchase price has been paid. Should I/We fail to pay Supreme Medical according to the terms and conditions listed on page 4, it is understood that Supreme Medical shall have the right to take immediate possession of the goods sold and not paid for. The undersigned agrees and consents to the exclusive jurisdiction and venue in the federal and state courts located in the County of Mobile, State of Alabama and specifically waives any objection to such jurisdiction or venue.

PERSONAL GUARANTEE

The undersigned, in consideration of Supreme Medical's agreement to sell medical supplies and equipment to Applicant personally guarantees the full and prompt performance and compliance of Applicant of all terms and conditions of this Credit Agreement, and the terms of sale stated on Supreme Medical's invoices. Furthermore, the undersigned personally guarantees the full payment of all outstanding indebtedness of the Applicant to Supreme Medical. In the event that Supreme Medical must use third-party assistance for collection of any delinquent balance due, I/We agree to pay interest at the rate of 1.5% per month (or such other rate allowed by prevailing law), attorney fees, collection fees and/or incurred court costs allowed by law. I understand that returned checks are subject to returned check charges and agree to pay any applicable fees associated with such charges. The undersigned agrees to notify Supreme Medical by certified mail of any change in ownership of the company and further agrees to be liable for all purchases should the undersigned fail to comply with said notification.

Dated this _____ Day of _____, 20 _____

_____ _____

Authorized Signature of Company Officer | Company Name

_____ _____

Print Name | Title

- **This form must be signed and returned with your application.**
- No application can be processed without a copy of this form.
- Any documents/pages that are part of this application that are faxes to Supreme Medical will be considered to be originals and accepted as such by Supreme Medical, its successors and assigns.

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CREDIT CARD AUTHORIZATION

Please complete this form if you wish to place a Credit Card on file with Supreme Medical

Date: _____

I, _____, give Supreme Medical Fulfillment Systems, Inc. (hereafter referred to as Supreme Medical) permission to process all charges related to any present or future order to the below referenced credit card. My signature below gives Supreme Medical the authority to process all requested transactions to the credit card listed.

_____

Name on the Credit Card

_____

Billing Address for the Credit Card

Card Type: ☐ Visa ☐ MasterCard ☐ Discover ☐ American Express

Is the Card a Corporate or Purchasing Card? (Company name is on card) ☐ Yes ☐ No

_____

Credit Card Number

Card Expiration Date: _____ CVV Code: _____ (3 or 4 digit verification code)

_____ _____

Authorized Signature of Company Officer Company Name

_____ _____

Print Name Title

PLEASE NOTE: Supreme Medical waives the 3% convenience fee for all credit card transactions that take place prior to order shipment. The 3% convenience fee will apply to any past-due account balances and/or invoiced transactions not charged prior to order shipment. Your signature implies agreement with this policy.

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TAX-EXEMPT PURCHASING

SALES & USE TAX EXEMPTION CERTIFICATE REQUIRED

- A copy of the sales and use tax exemption certificate issued by your state **must accompany** this application if your company is requesting tax-exempt purchasing.
- No multijurisdictional forms will be accepted.
- If your exemption certificate bears an expiration date, such as Florida's annual expiration date, you agree to supply new certificates to Supreme Medical within 14 days from receipt of the new certificate. Supreme Medical reserves the right to charge any applicable sales and/or use taxes if your certificate(s) has/have expired. **New annual forms must be faxed to: (251) 660-7533 each year**.
- Applicant agrees to pay any and all sales and or use taxes assessed by Supreme Medical because of expired certificates without dispute or delay.

TERMS & CONDITIONS

PAYMENT TERMS

Net 30 days from date of invoice.

REMIT-TO ADDRESS

Supreme Medical
PO Box 850247
Mobile, AL 36685-0247

PLACING ORDERS

Purchase Orders may be placed online through www.SupremeMedical.com, by Phone through your dedicated sales consultant (1-800-461-1370), by Fax (1-800-461-1277) or by email (orders@supplememedical.com)

RETURN POLICY

Product can be returned for 100% credit if returned within 30 days of purchase. Product returned after 30 days of purchase will be charged a 15% restock fee. Supreme Medical will only accept product returned within 90 days from the date of purchase. Products must be returned 6 months prior to date of expiration. Returns will not be accepted on special-order items. All returns must be returned in original packaging and must be in the same unit of measure as originally purchased. All returns are subject to inspection by Supreme Medical. No credit will be issued for product that we determine cannot be resold. **Each return should include a Return Merchandise Authorization (RMA) number.** Please call our Customer Service Department at 1-800-461-1370 to obtain a return authorization number. Please have the invoice number and date of purchase available when calling for a return authorization number. Unsolicited returns and returns without a RMA number will be charged an additional processing fee. Upon request, Supreme Medical can issue a UPS or Fedex call tag for an additional fee. Returns must be made within 30 days of RMA.

PRODUCT SHORTAGES/DAMAGES POLICY

Product shortages, shipping errors and concealed damages must be reported to our Customer Service Department at 1-800-461-1370 within 48 hours of receipt of shipment in order to receive credit. Obvious damages to packages/pallets should be notated with carrier upon delivery.

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GPO CONTRACTS YOUR FACILITY PARTICIPATES IN

PLEASE CHECK ANY GPO CONTRACTS/BUYING GROUPS YOU ARE A MEMBER OF:

☐ Vizient/MedAssets ☐ Novation/Provista ☐ Intalere ☐ Dignity Health ☐ Premier

☐ IMCO ☐ IHC (IMCO Home Care) ☐ VGM ☐ Vital Care ☐ Other _____

Customer Class:

☐ Home Health/Hospice	☐ Nursing Home/SNF/IRF/LTAC	☐ HME/DME Provider
☐ Physician Office	☐ Acute Care Hospital	☐ Independent Pharmacy
☐ E-Commerce Retailer	☐ ALF – Assisted Living Facility	☐ EMS
☐ Schools & Colleges	☐ Government	☐ Manufacturer
☐ Commercial (Business Use)	☐ Patient Home Delivery	☐ Workers' Compensation
☐ Behavioral/Mental Health	☐ Redistribution/B2B Dealer	☐ Outpatient Wound Center
☐ Telehealth	☐ Rehabilitation PT/OT	☐ Veterinary/Animal Health
☐ Third Party Biller	☐ Other _____	

WHERE DID YOU HEAR ABOUT SUPREME? _____

REQUIREMENTS CHECKLIST:

In order to expedite your application, please ensure all items in the checklist below are completed.

☐ **Fill out sections 1 and 2 completely. (REQUIRED)**

☐ **Fill out page 2 completely and sign. (REQUIRED)**

☐ If wishing to **Pay by Invoice**, fill out sections 3 and 4 completely.

☐ If wishing to **Pay by Credit Card**, fill out page 3 completely and sign.

☐ If requesting **Tax-Exempt Purchasing**, attach a copy of your Sales Tax Exemption for your state.

☐ If you are a member of a **GPO**, select which contracts your facility participates in on page 5.

FAX COMPLETED APPLICATION TO: (251) 660-7533

**** Do not write below. Authorization for Supreme Medical internal use only ****

Approval Date:
Approved By:
Payment Terms:
Sales Consultant Assigned:
Credit Limit:

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