CREDIT APPLICATION

BILLING INFORMATION

Clinic Name

Payment Contact Name

Address

Payment Contact Phone

State

Zip Code

Payment Contact Email

CREDIT INFORMATION

Credit Amount Requested

Terms Requested *Net 30 is standard*

Type of Business *(Corporation, Partnership, etc.)*

Years in Business

Federal Tax Identification Number

BANK REFERENCE

Name of Current Bank

Account Number

Bank Address

Phone Number

State

Zip Code

Fax Number

CONTINUED ON NEXT PAGE

TRADE REFERENCE #1

Company Name

Account Number

Company Address

Phone Number

State

Zip Code

Fax Number

TRADE REFERENCE #2

Company Name

Account Number

Company Address

Phone Number

State

Zip Code

Fax Number

I, the undersigned, hereby attest that all information provided in this application is true and factual. Furthermore, I attest that I have the authority to and hereby do authorize AOD CFAB, LLC to conduct credit checks through bank and trade references, credit reporting agencies, and any other sources as deemed reasonably necessary by AOD CFAB, LLC. I understand that any information obtained in relation to this credit application will be used solely for the purpose of making a decision of credit approval or denial and will be held in strict confidence with AOD CFAB, LLC.

Printed Name and Title *Must be a company Officer*

Signature

Date

☐ Approved as Requested ☐ Approved with Altered Credit Amount or Terms ☐ Denied

Approved or Denied By

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Date	Remarks