

Laerdal Medical Corporation Application for Credit

Customer Reference/Billing Information

This form must be fully completed in order to expedite your shipment. Incomplete applications will NOT be processed.

(Please Print or Type)

Name of Organization: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Contact Name: _____ Email Address (Required): _____

Please Check Type of Organization

- Municipality Fire Dept/EMS Volunteer Nonprofit Institution
- Private Business Corporation Private Individual Other (specify) _____

Does your organization have special billing requirements? Yes No

If so, please explain (Example: POs, vouchers, complete shipments) _____

When a formal purchase order cannot be provided, orders MUST be submitted on letterhead and signed by authorized personnel.

If we have questions regarding this application, who should we contact?

Name: _____ Title: _____ Phone: _____ Email: _____

Are you claiming exemption from your State & Local Taxes?

- NO (we are taxable) YES (we are exempt)

ID# _____

Please send a copy of your State Tax Exempt Certificate

Your state's applicable exemption certificate or statement must be included with your order for sales tax charges to be waived.

Authorization to Check Individual Credit History

Amount of credit requested: \$ _____

Credit references provided should include vendors where your company has a credit limit equal to or greater than the amount requested from Laerdal.

Customer Credit Trade References

1. Name: _____ Phone: () _____
Address: _____ Fax: () _____
City: _____ State: _____ Zip: _____ Email: _____
2. Name: _____ Phone: () _____
Address: _____ Fax: () _____
City: _____ State: _____ Zip: _____ Email: _____
3. Name: _____ Phone: () _____
Address: _____ Fax: () _____
City: _____ State: _____ Zip: _____ Email: _____

Bank Reference

4. Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Account No.: _____
Phone: () _____ Fax: () _____

Accounts delinquent over 30 days will be assessed a finance charge the lesser of 18% or the maximum allowed under local state regulations per annum.

Attorney and collection fees additional.

I hereby authorize the above-listed references to release my credit history in connection with a business transaction with Laerdal Medical Corporation.

I agree that a photocopy, e-mailed, scanned, or faxed copy of this authorization shall be as valid as the original.

Authorized Signature REQUIRED

Name (please print)

Date