

AMERICAN BREAST CARE, LP
CREDIT APPLICATION



Company Name	Phone
Address	Fax
City, State, Zip	Email
A/P Contact Person	A/P Phone
A/P Address (if different)	A/P Fax
City, State, Zip	A/P Email
Check One: <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Individual	Alternate Phone:
Names & Titles of Corporate Officers, Owners or Partners (Please list home address and phone for Partners or Individuals)	
Date Business Started	Fed Tax ID #
Name of Bank	Account #
Name of Bank Officer	Phone #
3 Trade Credit References	

CREDIT TERMS AND CONDITIONS

For the purpose of establishing and maintaining credit, the foregoing statement and information provided in and with this application are full, true and correct statements. The undersigned authorizes American Breast Care, LP to make inquiry into, to request, and to receive any information concerning financial and credit information from creditors or banks which American Breast Care, LP deems necessary for the granting and collection of a credit account. The undersigned also authorizes any creditor or bank to divulge such information. The undersigned understands that American Breast Care, LP will rely on the accuracy in all of the matters set forth in this application and all information obtained in determining whether to extend credit.

Our terms are: 2% 30 days from invoice date; net 45 days from invoice date. Discounts on payments that are postmarked *after* the prompt pay date will not be allowed. Applicant understands and agrees that payment in accordance with agreed upon terms is not contingent on Applicant's receipt of payment from any other party for goods provided by American Breast Care, LP.

The undersigned agrees to pay all costs of collection, including reasonable attorney fees, in the event Applicant fails to pay any charges when due. American Breast Care, LP reserves the right to withdraw credit to the Applicant at its sole discretion at any time.

The undersigned wishes to apply for credit with American Breast Care, LP in accordance with these terms and conditions which have been read, understood and accepted.

Print Name _____

Title _____

Signature _____

Date _____

2140 Newmarket Pkwy Ste 122 Marietta, GA 30067
Phone 866-830-1980 Fax 866-830-1991

www.americanbreastcare.com