SAMSON®
MEDICAL TECHNOLOGIES, L.L.C.

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Customer Application Form

Application must be completely filled out to process

Company Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Fax Number: _____

(Check One): ☐Corporation ☐Partnership ☐Proprietorship ☐Other_____

Purchasing Contact: _____ Email: _____

Purchasing Phone Number: _____ Fax: _____

Accounts Payable Contact: _____ Email: _____

Accounts Payable Phone Number: _____ Fax: _____

Pharmacy Contact: _____ Email: _____

Pharmacy Phone Number: _____ Fax: _____

Email for Electronic Invoicing: _____

Ship to Address, if different from above:

Address: _____

City: _____ State: _____ Zip Code: _____

Bill to Address, if different from above:

Address: _____

City: _____ State: _____ Zip Code: _____

Division or Subsidiary of: (Name of Firm) _____

Number of Employees: _____ Approx. Annual Sales $_____

Names and Titles of Officers and/or Principals

_____ _____

_____ _____

_____ _____

Pharmacy Distribution or Registration License Number_____

(please submit a copy of License)

Federal Tax ID Number_____

BANK REFERENCE:

Bank Name: _____ Branch: _____ Phone: _____

Address: _____ City: _____ State: ____ Zip Code: _____

Account Number: _____ Contact: _____

TRADE CREDIT REFERENCES: (or attach company profile)

1. Name: _____ Phone: _____ Fax: _____

Address: _____ City: _____ State: ____ Zip Code: _____

2. Name: _____ Phone: _____ Fax: _____

Address: _____ City: _____ State: ____ Zip Code: _____

3. Name: _____ Phone: _____ Fax: _____

Address: _____ City: _____ State: ____ Zip Code: _____

Three responses are required for processing