



Application for Credit Account

COMPANY NAME:

PHONE: FAX:

TRADING NAME:

POSTAL ADDRESS:

Name:

Street

Town/City

Postcode

DELIVERY ADDRESS: (If different from above)

Name:

Street

Town/City

Postcode

CONTACT NAME:

EMAIL:

ACCOUNTS PAYABLE CONTACT:

ACCOUNTS PAYABLE EMAIL:

NATURE OF BUSINESS:

DATE BUSINESS COMMENCED:

AVG MONTHLY CREDIT REQUIRED: UNDER \$1000 \$1000-\$9000 OVER \$9000 (Tick one)

BANK/BRANCH

TRADE REFERENCES 3 needed (not utilities, lawyers, accountants or banks)

NAME:

ADDRESS:

PHONE:

NAME:

ADDRESS:

PHONE:



TRADE REFERENCES (cont'd)

NAME:

ADDRESS:

PHONE:

DECLARATION

- Payment: Goods will be invoiced on dispatch and payment is made on 20th month following invoice.
- Ownership: Goods will remain the property of Capes Medical until fully paid for.
- The information supplied is true and correct and that we are/I am authorized to make this application.
- I/We acknowledge having read the credit terms as per this application including terms & conditions, and undertake to abide by them and to settle all accounts due to Capes Medical in accordance with them.
- Under the terms of the privacy act 1993, I/We authorize any person or business or organization to provide the company with such information as they require in response to their credit enquiries. I/We authorize the company to furnish to any third party, details of this application and any subsequent dealings that I/we may have with the company as a result of this application being auctioned by the company.
- Interest on all overdue accounts is payable by the applicant at the rate of 2% per month from the due date for payment until the date of actual payment.
- All costs and expenses (including debt collection charges and commission and/or solicitor's fees) incurred in recovering any overdue amounts will be paid by the applicant as a liquidated sum.

APPLICANTS SIGNATURE:

APPLICANTS NAME:

DATE:

**COMPLETE THIS SECTION ONLY
IF YOU ARE ELIGIBLE TO PURCHASE MEDICINES**

TYPE OF PROVIDER: Medical Practitioner Hospital Reg Nurse (Tick one)

Registration/Licence No:

Capes Medical require copy to be either emailed to accounts@capesmedical.co.nz or faxed to Capes Medical on 07 575 9333

OFFICE USE ONLY	
NAME: <input style="width: 95%;" type="text"/>	
SIGNED: <input style="width: 80%;" type="text"/>	DATE: <input style="width: 80%;" type="text"/>
CREDIT HAS BEEN: APPROVED / DECLINED	CUSTOMER ACCOUNT # <input style="width: 80%;" type="text"/>
REMARKS: <input style="width: 95%; height: 40px;" type="text"/>	