



Credit Application Form

Customer Information

Complete Legal Name :	<input type="text"/>		
Telephone :	<input type="text"/>	Fax :	<input type="text"/>
Email :	<input type="text"/>		
Billing Address:	<input type="text"/>		
City:	<input type="text"/>	State:	<input type="text"/>
		Zip :	<input type="text"/>
Shipping Address:	<input type="text"/>		
	<input type="text"/>	State	<input type="text"/>
		Zip :	<input type="text"/>

Business Description

Line Carried:	<input type="text"/>	Amount Of Sales:	<input type="text"/>
Date Established:	<input type="text"/>	Years at Location:	<input type="text"/>
		No. Of Employees:	<input type="text"/>

Business Structure

Corporation/Publicly Held:	<input type="text"/>
Partnership or Subsidiary, Name Of Parent Corp.:	<input type="text"/>
Sale Partnership:	<input type="text"/>
If a Division or Subsidiary, Name Of Parent Corp.:	<input type="text"/>
If Incorporated, Date Of Incorporation:	<input type="text"/>

Licensing Information:

Federal Tax # / Social Security #:	<input type="text"/>	Resale #:	<input type="text"/>
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Bank Reference:

Bank Name:	<input type="text"/>		
Savings Account:	<input type="text"/>		
Bank Address:	<input type="text"/>		
City:	<input type="text"/>	State:	<input type="text"/>
		Zip:	<input type="text"/>
Name Of Officer:	<input type="text"/>	Phone # :	<input type="text"/>
		Fax#:	<input type="text"/>

Trade References:

	<u>(Reference # 1)</u>		<u>(Reference # 2)</u>
Firm Name:	<input type="text"/>		<input type="text"/>
Address:	<input type="text"/>		<input type="text"/>
City:	<input type="text"/>		<input type="text"/>
State:	<input type="text"/>		<input type="text"/>
Zip:	<input type="text"/>		<input type="text"/>
Phone:	<input type="text"/>		<input type="text"/>
Fax:	<input type="text"/>		<input type="text"/>

Company Principals Responsibility For Business Transaction:

	<u>(Principal # 1)</u>		<u>(Principal # 2)</u>
Name:	<input type="text"/>		<input type="text"/>
% Of Ownership	<input type="text"/>		<input type="text"/>
SSS No.	<input type="text"/>		<input type="text"/>
Position:	<input type="text"/>		<input type="text"/>
Home Address:	<input type="text"/>		<input type="text"/>
City:	<input type="text"/>		<input type="text"/>
State:	<input type="text"/>		<input type="text"/>
Zip:	<input type="text"/>		<input type="text"/>

[Submit Form](#)[Reset Form \(Start Again\)](#)