



CREDIT APPLICATION FORM

Please complete the form below and fax back to Accounts receivable at: 800 463 3659. We will respond via Fax/Mail within one business day whenever possible. If you have any questions, please call us at: 800 665 3327			
BILLING ADDRESS:			
Business Name:			
Mailing Address:		City:	
Province:	Postal Code:	Phone:	
E-mail Address:		Fax:	
SHIPPING/RECEIVING ADDRESS			
Business Name:			
Address:		City:	
Province:	Postal Code:	Phone:	
Contact:		Fax:	
TYPE OF BUSINESS ENTITY			
Proprietorship	Partnership	Corporation	Other
Licensed Physical/Occupational Therapist ?		License No.	Province:
TYPE OF BUSINESS			
P & O	DME	Contractor	
School	Medical	Other:	
<i>IF P&O SELECTED ABOVE, COMPLETE THE FOLLOWING:</i>			
Name & License of CBCPO Practitioner:			
Myo. Qualified	C-Leg Qualified	Harmony Qualified	
OWNERSHIP			
Names:			
Social Insurance No. (If other than Corporation):			
Number of years in Business:			
ACCOUNTS PAYABLE			
Contact Person:			
Title:		Phone:	
BANK INFORMATION			
Name of Financial Institution:			
Address:		Account No.	
Contact :		Phone:	
CREDIT REFERENCES			
Name:		Name:	
Address:		Address:	
City, Province :		City, Province:	
P. Code:	Acct. #	P.Code:	Acct. #
Phone:	Fax:	Phone:	Fax:
YOUR SIGNATURE:			