



## New Account Form

Name and Title:			
Company name:			
Phone:	Fax:	E-mail:	
Registered company address:			
City:	State:	ZIP Code:	
Ship to:			
Sole proprietorship:	Partnership:	Corporation:	Other:
TYPE OF ACCOUNT PAYMENT METHOD REQUESTED (CIRCLE ONE)			
VISA MASTERCARD AMERICAN EXPRESS  CARD# EXPIRATION	LETTER OF CREDIT	C.O.D.	OTHER
BUSINESS AND CREDIT INFORMATION			
Primary business address:			
City:	State:	ZIP Code:	
How long at current address?			
Telephone:	Fax:	E-mail:	
Bank name:			
Bank address:	Phone:		
City:	State:	ZIP Code:	
Type of account	Account number		
Savings			
Checking			
Other			
BUSINESS/TRADE REFERENCES			
Company name:			
Address:			
City:	State:	ZIP Code:	
Phone:	Fax:	E-mail:	
Type of account:			
Company name:			
Address:			
City:	State:	ZIP Code:	
Phone:	Fax:	E-mail:	
Type of account:			
AGREEMENT			
1. All invoices are to be paid 30 days from the date of the invoice.			
2. Claims arising from invoices must be made within seven working days.			
3. By submitting this application, you authorize Minnesota Medical Development, Inc. to make inquiries into the banking and business/trade references that you have supplied.			
SIGNATURES			
Authorized signature:	MMDI Authorized signature:		
Date:	Date:		