E-mail Form | Print Form

CREDIT APPLICATION

General Information	Company Name:		FEIN Number (company):
	Doctor Name:		Social Security Number (owner):
	Address:		
	City:	State:	Zip:
	Phone:	Fax:	E-mail:
	Accounts Payable Contact:	Phone:	E-mail:

Credit Card Information	The following credit card will be charged for any unpaid amounts of past due invoices.		
	☐ Visa ☐ MasterCard	Card Number:	Exp Date:

Bank Information	Bank Name:		Contact Person:
	Checking Account Number:		Saving Account Number:
	Address:		
	City:	State:	Zip:
	Phone:		E-mail:

Trade Reference #1	Company Name:		Contact Person:
	Address:		
	City:	State:	Zip:
	Phone:		E-mail::

Trade Reference #2	Company Name:		Contact Person:
	Address:		
	City:	State:	Zip:
	Phone:		E-mail:

I certify that all the information on this form is true and correct. I have read and fully understand the credit terms on the catalogue, and herby authorize all trade and bank references to release any information relating to my account. If a credit line is extended, I understand that depending on my payment history, my credit line can be changed from time to time, with or without advanced notice at the sole discretion of Evergreen's credit department. For all my orders, I authorize Evergreen Herbs and Medical Supplies to charge my credit card for any unpaid amounts by the end of the net term payment period.

Signature: Print Name: Date:

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