**AFFLOVEST®**

# CREDIT APPLICATION

**The undersigned company is applying for credit with Tactile Medical and agrees to abide by the AffloVest DME Provider Terms and Conditions located at www.afflovest.com.**

**Send completed forms to Orders@Tactilemedical.com.**

## ORGANIZATIONAL INFORMATION

| | | |
|---|---|---|
| DME PROVIDER NAME: | | |
| DBA *(if different)*: | | |
| STREET ADDRESS: | | |
| CITY: | STATE: | ZIP: |
| CORPORATE PHONE: | CORPORATE FAX: | |
| COMPANY WEBSITE: | | |
| TYPE OF BUSINESS: | | |
| DATE BUSINESS ESTABLISHED: | NO. OF EMPLOYEES: | |
| HOW LONG AT CURRENT ADDRESS: | | |
| NATURE OF YOUR BUSINESS: | | |
| ANTICIPATED PURCHASES PER MONTH *(In US dollars)*: | | |
| AMOUNT OF CREDIT REQUESTED: | | |
| ARE YOU SALES TAX EXEMPT? ☐ YES ☐ NO | RESALE NUMBER: # | |
| HAVE YOU HISTORICALLY HAD CREDIT WITH INTERNATIONAL BIOPHYSICS CORPORATION (IBC)? ☐ YES ☐ NO<br>IF YES, UNDER WHAT NAME? | | |
| ACCOUNT PAYABLE CONTACT NAME: | E-MAIL ADDRESS: | |
| PURCHASING CONTACT NAME: | E-MAIL ADDRESS: | |

## ORGANIZATIONAL STRUCTURE

FEDERAL IDENTIFICATION NUMBER OR SOCIAL SECURITY NUMBER:

**SELECT ONE OF THE FOLLOWING ORGANIZATIONAL STURCTURES, CORPORATION, PARTNERSHIP OR SOLE PROPRIETORSHIP AND COMPLETE REQUIRED INFORMATION:**

### ☐ CORPORATION

STATE OF INCORPORATION:

NAMES, TITLES, AND ADDRESSES OF YOUR THREE CHIEF CORPORATE OFFICERS:

| | | | |
|---|---|---|---|
| CORPORATE OFFICER #1 | NAME: | TITLE: | |
| | E-MAIL ADDRESS: | | |
| | STREET ADDRESS: | | |
| | CITY: | STATE: | ZIP: |
| | PHONE: | FAX: | |

**Manufactured for Tactile Medical by**
**International Biophysics Corp.**
2101-2 E. St. Elmo Road, Suite 275, Austin, TX 78744 USA

Toll Free Tel: 800.575.1900
Toll Free Fax: 866.569.1912
afflovest.com

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| CORPORATE OFFICER #2 | NAME: | TITLE: | |
|---|---|---|---|
| | E-MAIL ADDRESS: | | |
| | STREET ADDRESS: | | |
| | CITY: | STATE: | ZIP: |
| | PHONE: | FAX: | |
| CORPORATE OFFICER #3 | NAME: | TITLE: | |
| | E-MAIL ADDRESS: | | |
| | STREET ADDRESS: | | |
| | CITY: | STATE: | ZIP: |
| | PHONE: | FAX: | |

## ☐ PARTNERSHIP

NAMES AND ADDRESSES OF PARTNERS *(add an additional sheet if needed)*:

| PARTNER #1 | NAME: | E-MAIL ADDRESS: | |
|---|---|---|---|
| | STREET ADDRESS: | | |
| | CITY: | STATE: | ZIP: |
| | PHONE: | FAX: | |
| PARTNER #2 | NAME: | E-MAIL ADDRESS: | |
| | STREET ADDRESS: | | |
| | CITY: | STATE: | ZIP: |
| | PHONE: | FAX: | |
| PARTNER #3 | NAME: | E-MAIL ADDRESS: | |
| | STREET ADDRESS: | | |
| | CITY: | STATE: | ZIP: |
| | PHONE: | FAX: | |

## ☐ SOLE PROPRIETORSHIP

NAME AND ADDRESS OF OWNER:

| OWNER | NAME: | E-MAIL ADDRESS: | |
|---|---|---|---|
| | STREET ADDRESS: | | |
| | CITY: | STATE: | ZIP: |
| | PHONE: | FAX: | |

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# AFFLOVEST®

## TRADE REFERENCES

| | | | |
|---|---|---|---|
| REFERENCE #1 | NAME: | E-MAIL ADDRESS: | |
| | STREET ADDRESS: | | |
| | CITY: | STATE: | ZIP: |
| | PHONE: | FAX: | |
| REFERENCE #2 | NAME: | E-MAIL ADDRESS: | |
| | STREET ADDRESS: | | |
| | CITY: | STATE: | ZIP: |
| | PHONE: | FAX: | |
| REFERENCE #3 | NAME: | E-MAIL ADDRESS: | |
| | STREET ADDRESS: | | |
| | CITY: | STATE: | ZIP: |
| | PHONE: | FAX: | |

## BANK REFERENCES

| | | | |
|---|---|---|---|
| BANK #1 | ACCOUNT # | | |
| | NAME OF BANK: | | |
| | STREET ADDRESS: | | |
| | CITY: | STATE: | ZIP: |
| | PHONE: | FAX: | |
| | CONTACT: | E-MAIL ADDRESS: | |
| BANK #2 *(if applicable)* | ACCOUNT # | | |
| | NAME OF BANK: | | |
| | STREET ADDRESS: | | |
| | CITY: | STATE: | ZIP: |
| | PHONE: | FAX: | |
| | CONTACT: | E-MAIL ADDRESS: | |

I represent that the above information is true and correct and is provided to induce Tactile Medical to extend credit to the applicant. My company and I authorize Tactile Medical to make such credit investigation as it sees fit, including contacting the above trade references and banks and obtaining credit reports. My company and I authorize all trade references, banks, and credit reporting agencies identified above to disclose to Tactile Medical any and all information concerning the financial and credit history of my company and myself. I understand that providing this information does not guarantee credit will be extended. I further understand that by signing this application I am personally guaranteeing payment for all items purchased by credit even if the credit customer is a corporation.

PRINTED NAME: TITLE:

SIGNATURE: DATE:

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