Nordson MEDICAL

APPLICATION FOR CREDIT ACCOUNT

THIS FORM MUST BE COMPLETED IN FULL TO BE CONSIDERED FOR OPEN CREDIT TERMS. THANK YOU.

Company Name: _____

Tax Exempt: ☐ Yes ☐ No **If yes, please send a tax exempt certificate per delivery address along with this application.*

D-U-N-S Number: _____ Credit Limit Requested ($):_____

Parent Company Name (if any): _____

Billing Address: _____

City: _____County: _____ State: _____ Zip: _____Country: _____

Shipping Address: _____

City: _____County: _____ State: _____ Zip: _____Country: _____

Telephone Number: _____ Fax Number: _____

Date Established: _____ Corp: ○ Partnership: ○ Proprietorship: ○

of Business: [Choose Industry]

Accounts Payable Contact: _____ A/P Phone No: _____

A/P Fax No: _____ A/P E-Mail: _____

Purchasing Contact: _____ Purchasing Phone No: _____

Purchasing Fax No: _____ Purchasing E-Mail: _____

TERMS OF ACCOUNT

TERMS: NET 30 DAYS FROM INVOICE DATE. ALL PAYMENTS MUST BE RECEIVED BY NORDSON MEDICAL BY THE DUE DATE AS STATED ON INVOICES. INVOICES ARE PAST DUE AFTER 31 DAYS.

Nordson MEDICAL Quality Policy: Nordson MEDICAL is committed to providing superior quality products and services by adhering to a quality management system that benefits our customers, employees and shareholders

FOR NORDSON MEDICAL USE ONLY

Application Reviewed By: _____

Credit Application Approved? ☐ Yes ☐ No If no, reason: _____

Date: _____ Customer ID#: _____

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