



9450 W Laraway Rd
 Frankfort, IL 60423
 www.Therafin.com

800-843-7234
 Fax 888-479-1515
 sales@Therafin.com

DEALER CREDIT APPLICATION

Therafin establishes Credit and Dealer accounts with an expectation of continued business. We look forward to developing a lasting relationship. To process a Dealer Credit Application and to establish an account, Therafin requires: 1) an opening order of at least \$250 2) a copy of your resale certificate 3) two positive INDUSTRY trade references if you wish to be apply for extended terms (otherwise you may prepay with a credit card).

(A) BUSINESS CONTACT INFORMATION

Name of Business:	
Company Address, City, State & Zip:	
Account Payable Contact Name:	A.P. Phone:
Sales Contact Name:	Sales Phone:
Email Address:	Company Fax:
Years in Business:	Federal Tax ID #:
Email Address to send Shipping Notification to:	
Invoice Preference: <input type="checkbox"/> Email <input type="checkbox"/> Fax	
Email Address 1:	Fax 1:
Email Address 2:	Fax 2:
Email Address 3:	Fax 3:

Please note: only provide trade references if you desire to apply for terms. If you prefer Prepay Terms- simply write "prepay" below

(B) TRADE REFERENCES

PLEASE SUPPLY TWO INDUSTRY REFERENCES

Please Note: The following companies **DO NOT** provide trade references – Abbott Ross, Airgas, Baxter, BSN Medical, Cardinal Distribution, Cardinal Health, Fisher & Paykel, FLA Orthopedics, Freedom Designs, Halyard Health, Independence Medical, Invacare, Ki Mobility, McKesson, MediUSA, Medline, Moen Homecare, Ottobock, Pari Respiratory, PCCA, Phillips, Resmed, Respironics, Sunrise Medical and Thermo Fisher and VGM.

REFERENCE 1

COMPANY:	
ADDRESS:	
PHONE:	FAX:
ACCOUNT #:	CONTACT:

REFERENCE 2

COMPANY:	
ADDRESS:	
PHONE:	FAX:
ACCOUNT #:	CONTACT:

REFERENCE 3

COMPANY:	
ADDRESS:	
PHONE:	FAX:
ACCOUNT #:	CONTACT:

*By submitting this application, you authorize Therafin Corporation, and its agents and assigns, the right to make credit inquiries to the business/trade references that you have supplied.

(C) PAYMENT: We accept ACH, Wire Transfer and Credit Card payments. Please contact ACCOUNTING@THERAFIN.COM for banking information.

Authorized Signature: _____ Title _____

Print Name: _____ Date _____

*****Please fax (888-479-1515) or email (sales@therafin.com) a copy of your Resale Certificate *****