3D MEDICAL DISTRIBUTORS LLC

Domestic Credit / Financial Application

Applicant: Thank you for your interest in opening a domestic account with 3D Medical Distributors. Please complete this form and submit it by following the instructions at the end of this form. A completed "Medic Shoes Product Purchase Agreement" must accompany this application . Instructions are provided for submission of your application at the end of this form. Your application will be processed and considered when these two documents are completed and received. Typical processing time is three (3) business days.

APPLICANT INFORMATION

Exact legal name of company (no trade names or dbas):

("Applicant")

(Sold To)

Address of Applicant's chief executive office:	Address where equipment will be located:
Street: _____	Street: _____
City: _____State: _____Zip:_____	City: _____State: _____Zip: _____
Phone :_____Fax: _____	Phone: _____ Fax: _____

(Bill To)	**(Ship To)**
Applicant's billing address:	Applicant's shipping address:
Street: _____	Street: _____
City: _____State: _____Zip:_____	City: _____State: _____Zip:_____
A/P contact: _____	Purchasing Contact:_____
A/P phone: _____	Purchasing phone:_____
A/P fax: _____	Purchasing fax:_____
A/P Contact Email: _____	Purchasing Contact Email: _____

Years Applicant has been in business:	Select ONE Type of Entity	Jurisdiction of Applicant's formation (e.g., Delaware):	Applicant's entity number:
_____	☐ SOLE PROPRIETOR ☐ PARTNERSHIP ☐ CORPORATION ☐ LLC ☐ NON- PROFIT ☐ S-CORP ☐ OTHER_____	_____	(This appears on the Articles of Incorporation, etc., issued by the state in which Applicant was formed.) _____

Applicant's Federal Tax ID #: _____	Is Applicant **exempt** from sales tax? ☐ Yes ☐ No
MDR license number (California customers only): _____	IF **TAX-EXEMPT**, PLEASE SEND / INCLUDE AN EXEMPTION CERTIFICATE FOR EACH STATE THAT WILL BE RECEIVING SHIPMENTS.
MDR license number expiration date: _____	

FINANCIAL / LEASING INFORMATION

Description of equipment Applicant desires to finance / lease:	Amount of financing requested:
	$ _____.00

Are you a member of a group purchasing or buying organization? _____ Y _____ N

If Yes, please indicate the group(s) and your membership number(s): _____ Group _____ Membership Number

_____ Group _____ Membership Number

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APPLICANT'S BUSINESS INFORMATION

TYPE OF BUSINESS THAT YOU OPERATE - PLEASE CHECK ALL THAT APPLY

Applicant BUSINESS TYPES:

- ☐ DME PROVIDER
- ☐ PHARMACY - CHAIN
- ☐ PHARMACY - INDIPENDENT
- ☐ RETAIL HOSPITAL
- ☐ PHYSICIAN OFFICE
- ☐ HEALTH CLINIC
- ☐
- ☐
- ☐ INPATIENT REHAB FACILITY
- ☐ LONG-TERM CARE FACILITY
- ☐ SKILLED NURSING FACILITY
- ☐ HST PROVIDER (DESCRIBE PRACTICE TYPE BELOW)
- ☐ OTHER (DESCRIBE BELOW)
- ☐ DISTRIBUTOR
- ☐ RETAIL CHAIN
- ☐
- ☐

BANK REFERENCE

Bank/Institution: _____ Account #: _____

Street: _____ Contact: _____

City _____State:_____ Zip: _____ Phone: _____ Fax: _____

TRADE REFERENCES

Business Name & Address	Contact Name	Phone	Account #
1._____	_____	(___)_____-_____	_____
2._____	_____	(___)_____-_____	_____

APPLICANT'S OWNERSHIP INFORMATION

Name of principal: _____

Social security #: _____-_____-_____% of ownership:_____%

Signature:_____

ADDRESS:_____

City: _____ State: _____ Zip: _____

Name of principal: _____

Social security #: _____-_____-_____% of ownership:_____%

Signature:_____

ADDRESS:_____

City: _____ State: _____ Zip: _____

**Where applicable 100% Ownership Information required…i.e. Sole Proprietors, Partnerships, etc. **

CONSENT AND AUTHORIZATION

APPLICANT CERTIFIES TO 3D MEDICAL DISTRIBUTORS, LLC. AND ITS AFFILIATES (COLLECTIVELY, "3DMD") THAT THE FOREGOING INFORMATION IS TRUE, CORRECT AND COMPLETE, AND THAT APPLICANT IS NOT AWARE OF ANY CIRCUMSTANCES THAT, WITH NOTICE OR THE PASSAGE OF TIME, WOULD MAKE ANY OF SUCH INFORMATION INACCURATE OR MISLEADING. APPLICANT ACKNOWLEDGES THAT 3DMD IS RELYING ON THE ACCURACY OF THE FOREGOING INFORMATION IN THE EVALUATION OF APPLICANT'S REQUEST TO OPEN AN ACCOUNT WITH RESPIRONICS. APPLICANT UNDERSTANDS AND ACKNOWLEDGES THAT IF, AT ANY TIME, 3DMD LEARNS THAT ANY OF THE FOREGOING INFORMATION IS INACCURATE OR MISLEADING, 3DMD MAY ELECT NOT TO OPEN AN ACCOUNT FOR APPLICANT, OR IF AN ACCOUNT HAS BEEN OPENED, 3DMD MAY CLOSE APPLICANT'S ACCOUNT, IN EITHER CASE IN THE SOLE DISCRETION OF 3DMD.

APPLICANT HEREBY AUTHORIZES EACH OF 3DMD AND EACH LEASING COMPANY OR OTHER FINANCIAL SERVICES COMPANY WHOM 3DMD ASKS TO CONSIDER PROVIDING FINANCING TO APPLICANT PURSUANT TO THIS FINANCIAL SERVICES APPLICATION, AND THEIR RESPECTIVE FUNDERS AND ASSIGNEES (COLLECTIVELY, THE "POTENTIAL FINANCING SOURCES") TO CONTACT ANY OR ALL OF THE ABOVE REFERENCES, AND TO OBTAIN AND USE ANY PUBLIC OR PRIVATE INFORMATION AVAILABLE TO MAKE A VALID CREDIT APPRAISAL OF APPLICANT. APPLICANT EXPRESSLY AUTHORIZES 3DMD TO DISCLOSE TO POTENTIAL FINANCING SOURCES, SOLELY FOR THE PURPOSE OF ENABLING SUCH POTENTIAL FINANCING SOURCES TO CONSIDER THE EXTENSION OF CREDIT TO APPLICANT, THIS COMPLETED FINANCIAL SERVICES APPLICATION, APPLICANT'S FINANCIAL STATEMENTS, AND ANY OTHER FINANCIAL OR BUSINESS INFORMATION PROVIDED BY APPLICANT TO 3DMD.

THE INDIVIDUAL EXECUTING THIS FINANCIAL SERVICES APPLICATION, WHO IS A PRINCIPAL OF THE APPLICANT (THE "UNDERSIGNED PRINCIPAL"), RECOGNIZING THAT HIS OR HER INDIVIDUAL CREDIT HISTORY MAY BE A FACTOR IN THE EVALUATION OF THE CREDIT HISTORY OF THE APPLICANT, HEREBY CONSENTS TO AND AUTHORIZES 3DMD AND EACH POTENTIAL FINANCING SOURCE TO OBTAIN, FROM TIME TO TIME AS NEEDED IN THE CREDIT EVALUATION PROCESS, ONE OR MORE CONSUMER CREDIT REPORTS ON THE UNDERSIGNED PRINCIPAL. THE UNDERSIGNED PRINCIPAL EXPRESSLY CONSENTS AND AUTHORIZES 3DMD TO DISCLOSE TO POTENTIAL FINANCING SOURCES, SOLELY FOR THE PURPOSE OF ENABLING SUCH POTENTIAL FINANCING SOURCES TO CONSIDER THE EXTENSION OF CREDIT TO APPLICANT, THIS COMPLETED FINANCIAL SERVICES APPLICATION (INCLUDING THE PERSONAL INFORMATION OF THE UNDERSIGNED PRINCIPAL CONTAINED HEREON), AND ANY OTHER PERSONAL, FINANCIAL OR BUSINESS INFORMATION PROVIDED BY THE UNDERSIGNED PRINCIPAL TO 3DMD. IN THE EVENT OF DEFAULT, AND IF THIS ACCOUNT IS TURNED OVER TO AN AGENCY AND/OR ATTORNEY FOR COLLECTION, THE UNDERSIGNED HEREBY AGREES TO PAY ALL REASONABLE FEES AND/OR COSTS OF COLLECTION WHETHER OR NOT SUIT IS FILED.

EACH OF APPLICANT(S) AND THE UNDERSIGNED PRINCIPAL UNDERSTAND AND CONSENT TO, THE TERMS AND CONDITIONS OF THIS CREDIT POLICY.

Name of Applicant: _____	Owner of Applicant in individual capacity:
Signature of Officer: _____	Signature: _____
Title of Officer: _____	Name printed/typed: _____
Date: _____	Date: _____

NOTICE: Potential Financing Sources to which this Financial Services Application may be forwarded may be subject to Section 326 of the USA PATRIOT Act, which requires such Potential Financing Sources to obtain, verify, and record information that identifies each applicant who applies for financing (including the principal or principals signing this Financial Services Application). Such Potential Financing Sources are also subject to the Equal Credit Opportunity Act, which prohibits creditors from discriminating against credit applicants on the basis of race, color, religion, national origin, sex, marital status, age, receipt of public assistance, or exercise of legal rights, including the good faith exercise of any right under the Consumer Credit Protection Act. A federal agency that administers compliance with this law is the Federal Trade Commission, Equal Opportunity, Washington, D.C. 2058, and the Bureau of Consumer Financial Protection, 1700 G Street NW., Washington D.C. 20006. Each applicant for credit may request (within 60 days of denial) a written statement of the reasons for any credit denial and such statement must be provided by the Potential Financing Source denying the credit application within 30 days of applicant's request.

Mail or fax completed application, latest financial statements, and tax exemption certificate(s) (if applicable) to:

3D MEDICAL DESTRIBUTORS LLC
Attention:
Financial Services Department
260 Geiger Road, Philadelphia PA 19115
(215) 437-6633
3dmedicald@gmail.com