Bound Tree medical

Making Precious Minutes Count...™

State and Municipal Account Application

Application must be completed and signed, with order attached, to initiate processing.

NAME _____ Parent or Subsidiary of _____

Do you or parent have an existing acct. #: ☐Yes ☐No If yes, please provide acct. #: _____

Billing Address _____

City _____ County _____ State _____ Zip _____

Shipping Address _____

City _____ County _____ State _____ Zip _____

Telephone Number w/Area Code: _____

Fax Number w/Area Code: _____

Are Vouchers Required for Payment: ☐Yes ☐No If yes, please submit with orders.

Amount of Credit Line Requested: _____

Funding Derived From: ☐ Local Government ☐ Donations ☐ Other: _____

FEIN #: _____ D & B #: _____

STATE SALES TAX EXEMPT: ☐ **Yes** ☐ **No**

If yes, you must provide Bound Tree Medical with a copy of your tax exemption certificate to avoid being charged taxes.

SHIPPING: Complete Only ☐ Partial Shipment Okay? ☐ Are PO's Required? ☐ Yes ☐ No

The following persons are authorized to purchase from this account:

1. Name _____ Title _____
2. Name _____ Title _____
3. Name _____ Title _____

NAME AND TELEPHONE OF PERSON RESPONSIBLE FOR ACCOUNTS PAYABLE:

Name _____ Phone Number _____

Fax Number _____ Email _____

Signature X _____

Print Name & Title _____ Date _____

Please mail the completed form to:
Bound Tree Medical
PO Box 8023
Dublin, OH 43016-2023

or Fax to: (866) 284-7504

Payment Remittance Address:
Bound Tree Medical, LLC
23537 Network Place
Chicago, IL 60673-1235

TIN #: 31-1739487

Dan Roantree/018