

**ABSOLUTE
MEDICAL
EQUIPMENT, INC.**

Application for Credit

Business Name _____

Type of Business _____ Date Started _____

Street Address _____

City _____ State _____ Zip Code _____

Phone Number _____ Fax Number _____

Billing Address _____

City _____ State _____ Zip Code _____

Please mark type: _____ Corporation _____ Partnership _____ Proprietorship

President Name _____ Phone _____

Vice President Name _____ Phone _____

Billing Contact _____ Phone _____

Federal ID # _____ Ga. Tax Exempt # _____

Business License Holder _____ License # _____

License Type _____ Date of Issue _____

BANK REFERENCE

Name _____ Contact _____

Address _____

Phone Number _____ Years with Bank _____

**ABSOLUTE
MEDICAL
EQUIPMENT, INC.**

Application for Credit

BUSINESS REFERENCES

Name	Address	Phone	Account #

By signing this form you authorize any inquiries necessary to establish credit accounts. I, the undersigned, attest that the information is true and correct to the best of my knowledge, and do accept personal responsibility for the payment of all invoices within terms.

Signed _____
(must be signed by owner or corporate officer) List Title

Date _____

For Office Use Only:	
Approved: _____	Denied: _____
Credit Limit: _____	
Issued By: _____	
Date: _____	
Review: _____	

Return Credit Application:
Absolute Medical Equipment, Inc.
30 East Gordon Road
Newnan, Georgia 30263
678-854-9234
678-854-9238 fax
Attn: Brett Temples