



NEW ENGLAND MEDICAL SUPPLY, INC.

365 Eddy Street, Providence, RI 02903

1-800-322-5887 • (401) 831-8030

Web Site: www.nemed.com Email: sales@nemed.com

Credit Application

**COMPANY NAME
AND ADDRESS**

*Please give your company name
& address exactly as they
Are to appear in our records.*

Name of Business: _____

Street Address: _____ P.O. Box: _____

City: _____ State: _____ Zip: _____

Telephone: () _____ Fax: () _____

Credit Limit Requested: _____

**GENERAL
INFORMATION**

Date Business Was Founded: _____

SINGLE PROPRIETORSHIP PARTNERSHIP CORPORATION

Nature of Business: _____

Name of Person Filling Our Form: _____

Signature: _____ Date: _____

I personally guarantee the payment of all invoices, within term issued by New England Medical Supply, Inc. for products accepted by myself, my company or my clients.

Date: _____ Signature: _____

Any and all legal claims to be litigated in the State of Rhode Island.

BANK REFERENCE

Name of Bank: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Telephone: () _____ Acct. #: _____

MAJOR SUPPLIER

Name: _____ Contact: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Telephone: () _____ Fax: () _____

Credit Limit: _____



NEW ENGLAND MEDICAL SUPPLY, INC.

365 Eddy Street, Providence, RI 02903

1-800-322-5887 • (401) 831-8030

Web Site: www.nemed.com Email: sales@nemed.com

Credit Application (continued)

MAJOR SUPPLIER

Name: _____ Contact: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Telephone: () _____ Fax: () _____

Credit Limit: _____

Name: _____ Contact: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Telephone: () _____ Fax: () _____

Credit Limit: _____