Evergreen™

CREDIT APPLICATION

General Information	Company Name:		FEIN Number (company):	
	Doctor Name:		Social Security Number (owner):	
	Address:			
	City:	State:	Zip:	
	Phone:	Fax:	Email:	
	Accounts Payable Contact:	Phone:	Fax:	Email:

Credit Card Information	The following credit card will be charged for any unpaid amounts by the end of the net 30 days payment period.		
	[ ] Visa [ ] MasterCard	Card Number:	Exp Date:

Bank Information	Bank Name:		Contact Person:
	Checking Account Number:		Saving Account Number:
	Address:		
	City:	State:	Zip:
	Phone:		Fax:

Trade Reference #1	Company Name:		Contact Person:
	Address:		
	City:	State:	Zip:
	Phone:		Fax:

Trade Reference #2	Company Name:		Contact Person:
	Address:		
	City:	State:	Zip:
	Phone:		Fax:

I certify that all the information on this form is true and correct. I have read and fully understand the credit terms on the catalogue, and hereby authorize all trade and bank references to release any information relating to my account. If a credit line is extended, I understand that depending on my payment history, my credit line can be changed from time to time, with or without advanced notice at the sole discretion of Evergreen's credit department **For all my orders, I authorize Evergreen Herbs and Medical Supplies to charge my credit card for any unpaid amounts by the end of the net 30 days payment period.**

Signature: **Print Name:** **Date:**

Evergreen Herbs and Medical Supplies, LLC
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