

De Kroyft - Metz & Co.

INCORPORATED

Health Care Distributor

201 N. E. ADAMS ST.

PEORIA, ILLINOIS 61602

PHONE (309) 673-3741

CREDIT INFORMATION FORM

Date _____

Bill to _____ Ship to _____

Address _____

City _____ State _____ Zip _____

Phone () _____ D.E.A. Number _____

E-mail address to which order confirmations are to be sent _____

FAX () _____

Owner/Manager _____ H.I.N. Number _____

If your account is exempt from Sales and/or Use taxes, we must have this form returned to our office with the proper information included. It must be signed by a responsible party within your organization or institution. Please also enclose a copy of your exemption letter from the Illinois Department of Revenue or a copy of your Certificate of Registration with the Illinois Department of Revenue. Make sure that your exemption letter contains the expiration date determined by the Illinois Department of Revenue. If your account is not exempt from Sales and/or Use taxes, there is no need to return that form. Providing us with this information will allow us to establish the account in the proper tax category.

Bank _____ Address _____

Bank Phone () _____

References: (Give only those for which you have an open account)

Name _____ Phone () _____

Address _____ City _____ State _____ Zip _____

Name _____ Phone () _____

Address _____ City _____ State _____ Zip _____

Name _____ Phone () _____

Address _____ City _____ State _____ Zip _____

Group Purchasing Organization Membership _____

Product Listing of items, with usage figures, to be purchased.

Mfg	Stock Number	Quantity	Unit	Monthly Purchase Volume
—	_____	_____	—	_____
—	_____	_____	—	_____
—	_____	_____	—	_____
—	_____	_____	—	_____
—	_____	_____	—	_____
—	_____	_____	—	_____
—	_____	_____	—	_____
—	_____	_____	—	_____
—	_____	_____	—	_____
—	_____	_____	—	_____

Please attach additional information as necessary.

OUR CASH PAYMENT TERMS ARE *NET 30 days, Date of Invoice*

I, the undersigned, agree to the above CASH PAYMENT TERMS, and understand that the account must be kept on a current basis or the account may be closed. If I fail to pay according to these terms, and am assigned to an attorney for collection, I agree to pay DeKroyft-Metz's reasonable collection and/or attorney fees, all court costs, and NSF fees, if applicable.

Account Name _____

By _____

Title _____

**PLEASE FAX TO 309-673-4775,
ATTN: CREDIT DEPARTMENT**