



idealmed.com, Inc.
2805 E. Oakland Park Blvd
Suite 352
Fort Lauderdale, FL 33306

Tel: (954)563-7847
Fax: (954) 563-5769
sales@idealmed.com
idealmed.com

CREDIT APPLICATION/ CUSTOMER PROFILE

CUSTOMER (Complete Legal Name. If corporate entity, use exact registered corporate name)			
Company		Federal Tax ID No. Tax Exempt/Resale Cert. No. (Attach copy)	
Address		City	County State Zip
Telephone	Fax	Contact Name	Title
[CIRCLE]: Physician Practice - Hospital - Outpatient Clinic - Mobile - Practice Mgmt. Corp- Other _____ [CIRCLE]: Non-profit - Proprietorship - Partnership - Corporation (S-Corp) If Partnership or Corporation, number of shareholders: _____		Years in Current Business _____ Years in Practice _____ Physician License #: _____ Date Issued _____	
REQUESTED TERMS _____ LEASE _____ BANK LOAN			
OTHER FINANCING:			
PERSONAL INFORMATION ON OFFICERS, PARTNERS, OR GUARANTORS			
Name		Title	Percent Ownership Social Security No.
Home Address		City State Zip	Home Phone No
Name		Title	Percent Ownership Social Security No.
Home Address		City State Zip	Home Phone No
COMPANY CREDIT REFERENCES - TWO YEAR HISTORY (Important to establish comparable credit history)			
Bank/Branch		City / State	Bank/Finance Co./Leasing Co. City / State
Type of Account		Account Number	Type of Account Account Number
_____ Depository _____ Loan			_____ Lease _____ Loan
Type of Account		Account Number	Type of Account Account Number
_____ Depository _____ Loan			_____ Lease _____ Loan
Contact Name		Phone #	Contact Name Phone #
TRADE REFERENCES - TWO YEAR HISTORY (Important to establish high credit and payment history)			
Name of Supplier		City/State	Telephone No. Contact Person
Name of Supplier		City/State	Telephone No. Contact Person

The undersigned is an authorized agent of the applicant with the authority to execute this Application on its behalf, and hereby warrants that the information provided above and/or attached is true and correct. The undersigned hereby authorizes Idealmed.com, Inc. its nominee or assignee, to contact any of the credit or trade references listed herein or any other sources regarding applicant's credit standing. Ideal Medical, after its investigation, may elect in its sole discretion to refuse to extend credit. Upon customer signing and acceptance by an authorized Ideal Medical Representative in Fort Lauderdale, FL, this document constitutes a written authorization to release the credit information requested.

Applicant Name _____

By (Signature) _____

Title _____

Date _____
