MDS Express Inc.
PO BOX 2507 BUFFALO, N.Y. 14240-2507
PHONE 716.662.9400
FAX: 716.662.9401

CREDIT APPLICATION

BILLING INFORMATION:

Company Name: ____Phone: (   ) _______________________

Street Address:____ Suite # ____________________

City: ____State: _____________ Zip: ________________________

Billing Address (*if different*) : ____

Accounts Payable Contact: ____Phone Extension: _____________

Accounts Payable Dept. Phone: (   )_______________________Fax: (   )____________________________

Special Billing Requirements *(ie, PO#, File Name, Reference #)*____

ORGANIZATION OF BUSINESS:

Sole Proprietorship: ______________ Partnership: _____________ Corporation (State Inc'd) ______________

Proprietor/Partners Name: _______________________________________Fed ID # ________________________

Nature/Type of Business: ____Yr Est'd ________________________

BANK REFERENCE:

Bank Name:____ Acct. #:_________________________________

Street Address:____Phone #: (   )_____________________

CREDIT REFERENCE:

Company:____________________Phone: (   )_____________Contact:__________________ # of Yrs______

Company:____________________Phone: (   )_____________Contact:__________________ # of Yrs______

PLEASE READ BEFORE SIGNING:

I, ______________________________ , *(title)* ___________________ authorize investigation of all statements in this application. Upon approval of credit, it is agreed that all payments will be made within 15 days from date of invoice. Any balance exceeding 15 days will be subject to a service charge of 1.5 % per month. The purchaser of these services agrees to pay all collection costs, including responsible attorney's fees, if account is turned over to an attorney or collection agency.

Signature _________________________________**Print** ___________________________**Date**______________

For Credit Department Use: Salesperson: Account Classification:
Date Received: Investigated by: