



Please complete all of the information required below in order to ensure a quick and efficient credit review process. Incomplete applications cannot be processed and will delay the process. Please submit your application by fax to 905-847-2708 or mail to R & M Health Care Inc., 790 Redwood Square Unit 8, Oakville, Ontario L6L 6N3. Once we have reviewed your application one of our customer service representatives will contact you. Please allow 3-5 business days for processing. All information provided is confidential and is used for the sole purpose of evaluating and granting credit terms.

Company Information

Type of Organization     Partnership     Sole Proprietorship     Corporation

Date Established    \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
                                 mm    dd    yy

Legal Name \_\_\_\_\_

Trade Name \_\_\_\_\_

Subsidiaries/Divisions \_\_\_\_\_

Principals & Positions \_\_\_\_\_  
\_\_\_\_\_

Provincial Sales Tax No. \_\_\_\_\_

Purchasing Contact \_\_\_\_\_ e-mail \_\_\_\_\_

A/P Contact \_\_\_\_\_ e-mail \_\_\_\_\_

List all authorized purchasers below:

Name \_\_\_\_\_ Title \_\_\_\_\_

Name \_\_\_\_\_ Title \_\_\_\_\_

Name \_\_\_\_\_ Title \_\_\_\_\_

Billing Address \_\_\_\_\_

City \_\_\_\_\_ Province \_\_\_\_\_ Postal Code \_\_\_\_\_

Tel. \_\_\_\_\_ Fax \_\_\_\_\_

Shipping Address \_\_\_\_\_

City \_\_\_\_\_ Province \_\_\_\_\_ Postal Code \_\_\_\_\_

Tel. \_\_\_\_\_ Fax \_\_\_\_\_

Banking Information

Bank Name: \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ Province \_\_\_\_\_ Postal Code \_\_\_\_\_

Tel. \_\_\_\_\_ Fax \_\_\_\_\_ e-mail \_\_\_\_\_

Account Number \_\_\_\_\_ Account Manager \_\_\_\_\_



Trade References

Company Name \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ Province \_\_\_\_\_ Postal Code \_\_\_\_\_  
Tel. \_\_\_\_\_ Fax \_\_\_\_\_  
Contact Name \_\_\_\_\_ Position: \_\_\_\_\_

Company Name \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ Province \_\_\_\_\_ Postal Code \_\_\_\_\_  
Tel. \_\_\_\_\_ Fax \_\_\_\_\_  
Contact Name \_\_\_\_\_ Position: \_\_\_\_\_

Payment Terms

First order and prior to credit approval	COD
Balance due (from date of invoice)	Net 30 Days
Full credit hold	at 60 Days
Prepayment required for future orders	at 90 Days
Automatic collection	at 120 days
*2% monthly interest charged on balances over 30 Days	

I, the undersigned, have read and agree to the payment terms of R & M Health Care, Inc. By submitting this application, I authorize R & M Health Care Inc. to make inquiries into the banking and business/trade references that I have supplied.

Name \_\_\_\_\_ Signature \_\_\_\_\_  
(Please print name of signing officer)

Title \_\_\_\_\_ Date \_\_\_\_\_

Name \_\_\_\_\_ Signature \_\_\_\_\_  
(Please print name of signing officer)

Title \_\_\_\_\_ Date \_\_\_\_\_