



North Coast Medical, Inc.  
780 Jarvis Drive, Suite 100  
Morgan Hill, California 95037  
www.ncmedical.com  
*Brands that Perform™*

## Application for Credit

Customer ID \_\_\_\_\_

### Company Information

Business Name: \_\_\_\_\_ Date Business Established: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ County: \_\_\_\_\_

Business Type: \_\_\_\_\_ ☐ Corporation ☐ Partnership ☐ Sole Proprietorship

### Accounts Payable Contact Information

Name: \_\_\_\_\_ Email: \_\_\_\_\_

Phone: \_\_\_\_\_

### Ownership Information

Name: \_\_\_\_\_ Federal ID#: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ County: \_\_\_\_\_

Phone: \_\_\_\_\_ CEO Name: \_\_\_\_\_

### Current Credit References

Name	Account Number	Phone
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

### Bank Information

Bank Name: \_\_\_\_\_ Acct Number: \_\_\_\_\_

Address: \_\_\_\_\_

Contact: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Requested Credit Limit Amount: \$ \_\_\_\_\_



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### Credit Agreement

Applicant hereby agrees to the terms and conditions as set forth herein:

1. All information is submitted for the purpose of requesting that North Coast Medical extend credit to the applicant or maintain credit for existing customers. Customer authorizes North Coast Medical to verify any references or financial information currently or previously provided pertaining to applicant's credit and/or financial responsibility.
2. Terms of sale are Net 30 Days from date of invoice. All invoices are payable in U.S. dollars.
3. All invoices are deemed prima facie evidence of amounts unless North Coast Medical receives notice of dispute within 20 days of invoice date. Items returned after 30 days of invoice date are subject to a minimum 15% restocking fee. Invoice(s) aged over 30 days from invoice date may be subject to a 1.5% per month late fee or the minimum interest rate under applicable law.
4. Returned checks may be subject to a \$25 fee for the first returned check and \$35 for all subsequent checks, per *Cal. Civ. Code §1719 (2003)*. Balances from returned checks that are paid with a credit card are subject to a 4% fee.
5. Accounts placed with outside collections due to non-payment within the credit terms shall be responsible for all reasonable attorneys' fees and collection agency fees.
6. Open invoice(s) that are paid with a credit card will be subject to a 2.5% processing fee. Prepaid orders do not incur the processing fee.
7. All customers are subject to sales tax, as applicable and required under state law, unless North Coast Medical has an original signed and dated resale certificate on file.
8. In the event North Coast Medical initiates any legal action under these terms, applicant shall be responsible for any and all costs to North Coast Medical, including without limitation, attorneys' fees. Applicants and any parties to this credit application agree to the jurisdiction of the state courts of the County of Santa Clara or the Federal Courts of California for the Northern District of California, San Jose Division.

**ALL INFORMATION SUPPLIED IS CORRECT AND I AGREE TO TERMS OF PAYMENT  
WITHIN 30 DAYS FROM DATE OF INVOICE**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Name (Print): \_\_\_\_\_ Title: \_\_\_\_\_

Please email completed Credit Application to [ARSupport@NCMedical.com](mailto:ARSupport@NCMedical.com)