

ACCOUNT SETUP – Fax to 281-727-0250

Ship To	Bill To (if different)
Contact Name:	Contact Name:
Facility:	Facility:
Department:	Department:
Address 1:	Address 1:
Address 2:	Address 2:
City, State, Zip:	City, State, Zip:
Country:	Country:
Email:	Email:
Phone/Fax:	Phone/Fax:
Name(s) of persons that will use the supplies:	
Name(s) of physicians overseeing the UDS program:	
Preferred Password: _____ (your email will be your login).	

Payment Options:	<input type="radio"/> Prepayment by credit card preferred
	<input type="radio"/> Prepayment for 1 st four orders and then 30 days with a limit to not exceed largest order amount.
	<input type="radio"/> Net 30 Days Terms requested (complete section below)

CONFIDENTIAL CREDIT APPLICATION & AUTHORIZATION (if Net 30 days is chosen)

Business References

1. Company Name:		Credit Limit:	
Terms:		Email:	
Contact:		Tel:	
2. Company Name:		Credit Limit:	
Terms:		Email:	
Contact:		Tel:	
3. Company Name:		Credit Limit:	
Terms:		Email:	
Contact:		Tel:	

Bank Information and Credit Information Release Authorization

Bank Name:			
Bank Address:			
Account Number:			
Account Manager:		Email:	
		Tel:	

This is to authorize the bank to release our bank credit information to Q-Diagnostics LLC. and its agent for the purpose of setting up a business account and terms and credit application.

Signed: _____ Dated: _____