

CSA Name _____ Extension _____ Date Prepared _____

Return completed and signed application along with your tax exemption certificate, if applicable, to fax number 608-531-2663.

Bill-To Name _____
Street _____
City _____
State _____ Zip _____ County _____
A/P Phone _____ Fax _____
A/P Contact Name _____
Company Website _____

Ship-To Name _____
Street _____
City _____
State _____ Zip _____ County _____
Alt Phone _____ Fax _____
Alt Contact Name _____
Email _____

Business Information:

Federal Tax ID # _____ How Long in Business _____ yrs _____ mos
Number of Employees _____ Dun & Bradstreet Number (if applicable) _____

What is the primary nature of your business with us (please mark only one of the following):

- Radio button options for business types: Ambulance, Clinic, Distributor, Doctors Office, Export, Fire Department, Government, HME/DME, Hospital, Laboratory, Leasing Company, Nursing Home, OEM/Original Equip Manuf, Prison, Repair/Service, Free Standing Surgery, University/Teaching Institute, Veterinary Clinic, Women's Clinic, Other (specify)

Do you use inhaled anesthesia for surgery? Yes No
Do you repair Datex-Ohmeda equipment? Yes No
Do you re-sell or rent Datex-Ohmeda equipment? Yes No
If yes to 3, what geographical area will be the destination of the equipment? US International
Are you a member of a corporate or group purchasing organization? Yes No If yes, please state. _____

Financial Information:

Should we charge you sales tax? Yes No If no, you must provide a copy of your exemption certificate.

Table with 4 columns: Name, Address, Phone, Account #. Contains two rows of trade references.

Bank Reference:

Bank Name _____ Contact _____ Account # _____
Address _____ Phone _____

By signing below you agree to our terms of Net 30 days. You also agree to pay for any and all collection and legal fees for unpaid balances that require collection attendance.

Signature _____ Title _____ Date _____

For Internal Use Only:
Account # _____ Approval Date _____ Comments _____

