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NEW CUSTOMER APPLICATION

Company Name: _____

Shipping Address: _____

City: _____ State: _____ Zip Code: _____

Country: _____

Telephone #: _____ Fax # _____

Billing Address: _____

City: _____ State: _____ Zip Code: _____

Purchaser's Name: _____

Contact E-mail: _____

Person Responsible for
Accounts Payable: _____

Business
Owner's Name: _____ Tax ID#: _____

Thank you for your interest in Tiara Medical Systems, Inc. Your order will be processed immediately after receiving this information you will be assigned a customer ID number.

Please Note: Our payment terms are Net 30 Days. Thank You.

Internal Use Only

Customer Code:
__DIS__HCF__HME__IRT__MD__OEM__SL

Processed by: _____ Date: _____