



Welcome to Medical Specialties Distributors, LLC.

...Delivering Healthcare Products & Biomedical Services...for Life!

Thank you for choosing Medical Specialties Distributors. Before we can begin to service you, the following new account forms must be completed:

1. **New Account Set-Up and Change Form**
2. **Credit Application**
3. **State Resale Certificate ***
4. **Current Pharmacy License and/or DEA Certificate *** (If you do not hold a Pharmacy License and/or DEA Certificate, please forward a copy of your State License, M.D. License, Wholesaler License or other license that permits you to purchase and/or distribute any pharmacy legend products)
5. **Tax Exempt Certificate *** (if applicable)
6. **Inside Delivery Needed (Yes / No)**

Please let us know if you do not have the capability of accepting truck orders without this special service.

* Not enclosed

Please fax completed forms to us at **(781) 344-8320**. Upon receipt of all documentation, we will set up your account and establish your line of credit so that you can begin placing orders.

If you need assistance or have any questions, please call Customer Service at: **(800) 967-6400** between the hours of 8:00am – 8:00pm EST.

**We look forward to servicing your
Healthcare Products and
Biomedical Rental Equipment needs!**

**Richard F. Worthen
Executive VP, Sales and Marketing**



New Account Information Form

Date: _____ Account # _____

Bill To:

Company Name: _____

Street: _____

City: _____ County: _____ State: _____ Zip: _____

Accounts Payable Manager: _____

Accounts Payable Telephone: _____

Fax: _____ Email: _____

Ship To:

Company Name: _____

Street Name: _____

City: _____ County: _____ State: _____ Zip: _____

Purchasing Manager: _____

Purchasing Telephone: _____

Purchasing Fax: _____ Purchasing Email: _____

Buying Group Member Y / N: If Y, please list memberships: _____

How did you hear of MSD? _____

PLEASE TELL US ***** ABOUT YOURSELF

How many years have you been in business? _____

What is your expected amount (if known) of Product purchases per month? _____

What is your expected amount (if known) of Rentals per month? _____

Please indicate if you would like us to register you to order online Yes _____ No _____

Please check the one that best describes your business classification:

- Home Infusion Provider Hospital Affiliated Infusion Provider Hospital
- Home Healthcare Provider Closed Door Pharmacy Retail Pharmacy
- Oncology Office/Suite Hospice Organization Manufacturer
- Physician's Office Dialysis Center Infusion Suite/Clinic
- Long-Term Care Facility Nursing Agency Sub-Acute Care Facility
- Veterinary Clinic Respiratory Therapy / DME Dental Office
- HME / DME Provider Outpatient Surgery Center HMO/Managed Care
- Research Facility Educational Facility Government
- Diagnostic Laboratory Diagnostic Imaging Center Blood Collection Center
- Emergency Medical Service Distributor



Credit Application

COMPANY

Name _____

Billing Address _____

City _____ State _____ Zip _____ Telephone _____

Federal Tax I.D. # _____ Duns # _____ Fax # _____

Type of Business (check one) _____ Corporation _____ Partnership _____ Sole Proprietor

Names of Principals _____

President

Vice President

Secretary

Treasurer

BANK REFERENCE

TRADE REFERENCE #1

Name _____

Name _____

Address _____

Address _____

Contact Name _____

Contact Name _____

Telephone _____

Telephone _____

Check Acct. No. _____

Account No. _____

TRADE REFERENCE #2

TRADE REFERENCE #3

Name _____

Name _____

Address _____

Address _____

Contact Name _____

Contact Name _____

Telephone _____

Telephone _____

Account. No. _____

Account No. _____

Please attach current financial statements (audited, if available).

I/We hereby authorize Medical Specialties Distributors, LLC. to conduct a complete credit investigation of the Company named above, including but not limited to, the references provided herein. (Note—all such information received will be kept strictly confidential and used for the sole purpose of granting credit.) It is agreed that the terms of sale for all purchases are net 30 days from invoice date, unless otherwise agreed in writing, and payment will be made in accordance with those terms. I/We agree to pay all collection expenses, including reasonable attorneys fees, together with interest at the rate of 2% per month on any past due balance. I/We further agree that any lawsuits will be governed under the laws of the Commonwealth of Massachusetts.

Signature

Print Name and Title

Date