



Application for Credit

Type or Print Clearly

P.O. Box 276, 206 Jefferson, Ellis, KS 67637
Phone: 888-321-3382 Fax: 785-726-4131

Company Name: _____ Other Company Name(s): _____

Address: _____ City: _____ State: _____ Zip: _____

Accounts/Payable Contact: _____
First Last Name Phone No.: _____ Ext: _____

Phone: _____ Fax: _____ E-Mail Address: _____

BUSINESS INFORMATION

Type of Business: _____ Year Started: _____ Organized Under Laws of: _____ (State)

Resale #: _____ Fed./State Tax ID #: _____

TRADE REFERENCES

Bank Name: _____ Street: _____

City: _____ State: _____ Zip: _____ Account Number: _____

Contact Person: _____ Phone: _____ Fax: _____

Name: _____ Street: _____

City: _____ State: _____ Zip: _____ Account Number: _____

Phone: _____ Fax: _____

Name: _____ Street: _____

City: _____ State: _____ Zip: _____ Account Number: _____

Phone: _____ Fax: _____

Name: _____ Street: _____

City: _____ State: _____ Zip: _____ Account Number: _____

Phone: _____ Fax: _____

RELEASE OF AUTHORITY TO VERIFY

I hereby authorize the above bank and trade references to release the information necessary to assist Sunflower Medical LLC in approving our line of credit. I release any person or organization supplying or inquiring about such information from all liability in connection with the furnishing or use of such information.

Signature Title Date ____/____/____

Print Name

Please Fax or Mail to Sunflower Medical

Fill out application in it's entirety. A delay in processing will occur if information is left blank.