



INSTRUCTIONS FOR APPLICATION FOR CREDIT TERMS

Thank you for applying to Aspen Medical Products for an open line of credit. In order to expedite your request for credit, please follow these instructions when completing your Application:

Required Information:

- Please fill out the **entire form**, *legibly and completely*
- Please **sign** the first signature section on page 2 (agreeing to the open credit payment terms and authorizing our investigation of your credit history), *in ink*
- **Trade references** should include **three** sources who: (a) are unrelated to Aspen, (b) you have purchased from in the past twelve months, and (c) have authorized similar credit terms and amounts as those you are requesting.
 - Office supply companies, utilities, phone companies, leasing companies, mortgage companies and the like are not appropriate trade references.
 - Since we will contact your references, the application process will be expedited if you confirm in advance that your references are willing to respond to requests for credit information on your company.

If any of the requested information is not included, it will delay our ability to process your application and thus delay our ability to establish a credit line for you.

Optional information:

The credit application process may be expedited by providing the following additional, optional information:

- A personal guarantee, by signing the second signature section on page 2
- Company financial statements, or in the case of a personal guarantee, personal financial statements.

Please note that none of the above information, including a personal guarantee and/or financial statements, will guarantee that credit will be extended, however, it will expedite the credit application process.

We appreciate your business and will do everything we can to help you through the credit process.

Sincerely,

The Aspen Credit Team

Email: AR@aspenmp.com

Phone: (800) 295-2776

Fax: (949) 681-0308



□ For internal use only:
 Date: _____
 Customer No: _____
 Sales Rep: _____

CREDIT APPLICATION

To expedite your application, please complete in full. Please type or print legibly in black or blue ink.

BILL TO:

Facility Name _____ Phone No. _____
 Bill To e-mail address _____ Fax No. _____
 Address _____ Year Business Opened _____
 City _____ State _____ Zip _____ County _____

CIRCLE ONE: Incorporated Partnership Sole Proprietor DBA

SHIP TO: (If different from Bill to Location)

Facility Name _____ Phone No. _____
 Address _____ Fax No. _____
 City _____ State _____ Zip _____ County _____

OWNERS:

Name _____ Title _____ SS# _____
 Home Address _____
 City _____ State _____ Zip Code _____ Phone _____

Name _____ Title _____ SS# _____
 Home Address _____
 City _____ State _____ Zip Code _____ Phone _____

Name _____ Title _____ SS# _____
 Home Address _____
 City _____ State _____ Zip Code _____ Phone _____

CONTACTS:

Accounts Payable _____ Phone No. _____
 Accounts Payable e-mail _____ Fax No. _____
 Purchasing _____ Phone No. _____
 Purchasing e-mail _____ Fax No. _____

NEW ORDERS WILL NOT SHIP UNLESS TAX I.D. AND SALES TAX INFORMATION ARE COMPLETE

- Federal Tax I.D. No. _____
- State Tax I.D. No. _____

• **YOUR ORGANIZATION IS ONE OF THE FOLLOWING. PLEASE COMPLETE:**

1. Product purchased for resale only. Resale Certificate No. _____
Please provide a copy of resale certificate.
2. Product to be purchased is tax exempt in State _____ County _____
Please provide a copy of exempt certificate.
3. Organization is exempt from sales and use tax due to nonprofit and / or charitable nature.
Please provide a copy of exempt certificate.
4. A taxed facility at _____ %



Customer No: _____

TRADE REFERENCES (please provide references offering credit terms) :

Name _____ Acct. No. _____
Address _____
City _____ State _____ Zip _____
Phone No. _____ Fax No. _____
Contact Name _____ Alternate Phone No. _____

Name _____ Acct. No. _____
Address _____
City _____ State _____ Zip _____
Phone No. _____ Fax No. _____
Contact Name _____ Alternate Phone No. _____

Name _____ Acct. No. _____
Address _____
City _____ State _____ Zip _____
Phone No. _____ Fax No. _____
Contact Name _____ Alternate Phone No. _____

BANK or SAVINGS & LOAN ASSOCIATION:

Name _____ Branch No. and Address _____

Account No. _____ Contact Name _____ Phone No. _____ Fax No. _____

Name _____ Branch No. and Address _____

Account No. _____ Contact Name _____ Phone No. _____ Fax No. _____

OPEN ACCOUNT CREDIT TERMS:

1. All invoices are due and payable within 30 days from the invoice date.
2. At the discretion of ASPEN MEDICAL PRODUCTS, any account with a delinquent balance may have credit terms revoked and changed to prepaid.
3. ASPEN MEDICAL PRODUCTS reserves the right to charge the Customer a monthly service fee of 1.5% on the past due balance.
4. Customer agrees to pay all legal fees, and collection and court costs incurred by ASPEN MEDICAL PRODUCTS in enforcing these terms and conditions, including attorneys fees incurred by ASPEN MEDICAL PRODUCTS, whether or not suit is filed.
5. Customer authorizes ASPEN MEDICAL PRODUCTS to obtain credit reports, trade reports and bank references for the purpose of determining the extension or continuation of credit to the Customer.
6. This agreement has been entered into and is to be performed in the County of Orange, State of California, and any action brought hereunder shall be brought in the federal or state courts located in said county and state.
7. Customer warrants and represents to ASPEN MEDICAL PRODUCTS that Customer is solvent and is able to pay its obligations as they become due. Customer will not place any order with ASPEN MEDICAL PRODUCTS unless it reasonably believes that it will be solvent and able to pay its obligations as they become due at the expected time of shipment.
8. If Customer provides misleading credit information to ASPEN MEDICAL PRODUCTS of any kind or nature, ASPEN MEDICAL PRODUCTS may without further notice cancel any orders in house, or any deliveries in progress to Customer. Any false or misleading information provided by Customer shall be construed as a material default, and any invoices outstanding shall be immediately due and payable in full.
9. It is the Customer's responsibility to notify ASPEN MEDICAL PRODUCTS of any changes to Customer's tax status. It is Customer's responsibility to remit tax payment due to each state on any tax not collected by ASPEN MEDICAL PRODUCTS.

The undersigned warrants that all information is correct, has read, accepted and agrees to be bound by all of the terms set forth in this document and in each contract entered into by the undersigned or his/her agents. It is understood and agreed that the undersigned specifically consents to ASPEN MEDICAL PRODUCTS investigation of the applicant's credit history and utilization of credit reporting services for information on the undersigned. ASPEN MEDICAL PRODUCTS may use this agreement with any bank or other kind of financial institution for the purpose of obtaining any or all of Customer's business financial information of any kind or nature. Facsimile copies will be accepted as originals.

Date: _____

Print Name: _____

Signature: _____

Title: _____

CONTINUING PERSONAL GUARANTEE:

For valuable consideration, receipt of which is hereby acknowledged by the undersigned, the undersigned agree to, and do hereby personally guarantee, jointly and severally, the prompt payment to ASPEN MEDICAL PRODUCTS of any present or future indebtedness whatsoever of Applicant to ASPEN MEDICAL PRODUCTS for goods supplied by ASPEN MEDICAL PRODUCTS to Applicant, including interest, and costs and expenses of collection, litigation, or arbitration (including attorneys fees), whether or not ASPEN MEDICAL PRODUCTS proceeds against Applicant for the same.

This Guarantee shall continue indefinitely until revoked in writing by the undersigned by registered or certified mail upon its receipt by ASPEN MEDICAL PRODUCTS; and thereafter, the undersigned shall not be liable for any indebtedness incurred by the Applicant after the effective date of revocation. Liability of any guarantor hereunder shall not be affected by ASPEN MEDICAL PRODUCTS granting Applicant or any other guarantor hereunder any renewal or extension of credit, any alteration or compromise in the terms or amount of payment or indebtedness, or the like. Guarantor agrees that the liability hereunder shall be the immediate, direct, and primary obligation of guarantor and shall not be contingent upon ASPEN MEDICAL PRODUCTS exercise of enforcement of any remedy it may have against Applicant.

CONSENT TO OBTAIN CONSUMER CREDIT REPORT:

The undersigned individual, who is either a principal or sole proprietor of the credit applicant, recognizing that his or her individual credit history may be a factor in the evaluation of the applicant, hereby consents to authorize the use of a consumer credit report on the undersigned by the above named business credit grantor, from time to time as may be needed, in the credit evaluation process. ASPEN MEDICAL PRODUCTS may use this agreement with any bank or other kind of financial institution for the purpose of obtaining all personal and business financial information of any kind or nature in the name of ASPEN MEDICAL PRODUCTS, and/or the entity it represents. Facsimile copies will be accepted as originals.

Date: _____

Print Name: _____

Signature: _____