

ORTHOFEET ACCOUNT APPLICATION

Midsouth Therapeutic, 4853 Normandy Dr. Frisco, TX 75034

Tel: 972-712-5407

Fax: 972-712-3319

Name _____ Date _____

Address _____

City _____ State _____ Zip _____ Tel. (____) _____

E-Mail: _____ Federal Tax I.D. _____

Names of Authorized Owner(s):

1. _____

2. _____

Name of Officers:

1. _____

2. _____

Check One: Corporation Proprietorship Partnership **In Business Since** _____

Bank References:

Bank Name: _____ Account No. _____

Address _____

City _____ State _____ Zip _____ Tel. (____) _____

Business References:

1. Company Name _____ Address _____

City _____ State _____ Zip _____ Tel. (____) _____

2. Company Name _____ Address _____

City _____ State _____ Zip _____ Tel. (____) _____

3. Company Name _____ Address _____

City _____ State _____ Zip _____ Tel. (____) _____

Amount of Credit Requested _____

Credit Card Information:

Credit Card: Visa _____ MasterCard _____ American Express _____

Credit Card #: _____ Expiration Date: _____

Name (as it appears on the card): _____

Signature: _____

____ I agree to payoff all invoices within 30 days of invoice date. I authorize you to use the above credit card as a guarantee of payments for orders that are not paid within 30 days of the invoice date.

____ Please charge the above credit card for all my orders.

I hereby authorize verification of the above information.

(Signature)

(Title)

(Date)