

Hospital or Imaging Center Application

Please provide some information about your organization.

Hospital name: _____

Parent or Affiliated Company: _____

Sales Tax Resale # _____

State Issued: _____

Federal Tax ID #: _____

Billing Address: _____

Ship-to Address: _____

Accounts Payable Contact:

Name: _____
Telephone Number() _____
Fax Number () _____
E-Mail: _____

Purchasing Contact:

Name: _____
Telephone Number() _____
Fax Number () _____
E-mail: _____

I/we hereby authorize your investigation of credit bureaus or other agencies as to my/our credit and financial responsibility. I/we understand that an open account, if approved, is due and payable 30 days from the date of invoice and I/we agree to pay all invoices in accordance with these terms and understand that failure to pay in a timely manner may cause NAI to revoke open billing status. In the event that it becomes necessary to collect under this agreement, the undersigned personally guarantees and promises to pay such open accounts, including reasonable collection costs and attorney fees.

Signature:

Date:

Title:

Please return to NAI Tech Products
Fax: 530 887-1108

For NAI Tech Products Use Only

Date Received: _____ Submitted by: _____ Checked by: _____

Account Number: _____ Credit Limit: _____ Payment Terms: _____

Approval: _____