Please email your completed application to: Info@urgentsurgerysolutions.com or fax it to 877-760-4693

Credit Application

Legal Name and DBA Name (if applicable)	Phone# Fax# Email:

Ship To Address: Please check this box if billing is the same as shipping	City:	State:	Zip:
Bill To Address:	City:	State:	Zip:

Please fill the applicable areas below

Type of Business	Sales Tax Exempt ID#	MD: ME License #	DEA License #
Fed Tax ID#	State License #	Pharmacist License#	Pharmacy License #

Accounts Payable Information

Contact Name:	Phone#	Email:

Ownership (list each person owning 10% or more; attach additional pages if needed)

Name / Title	Home Address
Name / Title	Home Address

Vendor References

Name	Address	Telephone	Account #
Name	Address	Telephone	Account #

Banking Information

Bank Name:	Branch Address:	City:	State:	Zip:
Name of Bank Representative	Checking Account #	Telephone #	Fax #	

This application is submitted for the purpose of inducing Urgent Surgery Solutions, Inc. (USS) to extend credit to Applicant. The undersigned represent(s) that all information contained herein is true and correct and that (USS) may rely on said information in deciding whether to extend, decline, or discontinue credit. The undersigned agree(s) to immediately notify (USS) in writing of any changes in the information provided, including but not limited to, any change in ownership, change of business name, change of business location, or change in the financial condition of the business of the undersigned individual(s). The undersigned hereby authorize(s) (USS) to contact the above listed trade and banking references to verify the information listed above. The undersigned agree(s) to release all persons and/or entities, including (USS), using or supplying the information from any claims and/or losses resulting therefrom. The undersigned agree(s) to pay all invoices in accordance with the agreed upon terms of the sale as printed on each invoice. Applicant expressly authorizes Company to process any and all of Applicant's payments made by check as an "ACH Debit" to the Buyer's checking account. Applicant acknowledges that all invoices sent by (USS) shall be deemed true and correct unless the Applicant disputes the invoice, or any portion thereof, in Writing within two (2) days of the date of the invoice. If only a portion of an invoice is disputed, Applicant shall remit the undisputed portion in accordance with the terms of the invoice and include an explanation of the dispute to facilitate resolution. A $50 late charge shall be assessed each month the invoice is past due. Past due balances are subject to a service charge of 1.5% per month (or the maximum amount permitted by law, if less). All payments are applied first to any service charge and then to the oldest unpaid invoice. The undersigned shall be responsible for payment of all costs incurred by (USS) to collect past due invoices, including without limitation, NSF fees, attorney's fees, collection agency fees, and court costs. The undersigned proprietor(s), partner(s), and/or officer(s) of the Applicant, hereby agree to personally guarantee and assume all the obligations and responsibilities for any and all debts the Applicant shall incur in connection with the Applicant's purchases from (USS) commencing on this date until such time as (USS) acknowledges the termination of said personal responsibility in writing. I/We have read and agree to all the terms and conditions stated on this credit application.

Signature (Personal Guarantee)	Print Name and Title	Date
Signature (Personal Guarantee)	Print Name and Title	Date

Please include as many copies of the Corresponding Licenses as possible:
Clinic License, Pharmacy License, MD License, or DEA License

950 N. Francis Pl, Ste.111, St. Louis, MO, 63105