CREDIT APPLICATION & AGREEMENT

Company Name: _____

Street Address:_____

City: _____State:_____Zip:_____

Billing Address: _____Attn:_____

City: _____State:_____Zip:_____

Phone: (_____) _____ Fax: (_____) _____

e-mail _____

Are you a Corporation ☐ Partnership ☐ Individual ☐ number of years in business? _____

Federal ID # _____ DUNS: _____ Reseller #_____

Credit Limit Requested: _____

Please check by which method you wish to receive your invoices:

Mail ☐ FAX ☐ e-mail ☐

LIST BANK REFERENCES BELOW:

1. **Bank Name:** _____ **Contact Name:** _____
   Phone: (_____) _____ Fax: (_____) _____
   Account Number: _____TYPE_____

2. **Bank Name:** _____ **Contact Name:** _____
   Phone: (_____) _____ Fax: (_____) _____
   Account Number: _____TYPE_____

3. **Bank Name:** _____ **Contact Name:** _____
   Phone: (_____) _____ Fax: (_____) _____
   Account Number: _____TYPE_____

Company agrees that extension of credit by Independent Drug Testing Supply shall be subject to and in consideration of the following:

1. Terms are those stated on the invoices. All amounts are due in accordance to those terms.
2. Past due balances are subject to a 1 ½ % per month service charge on the unpaid balance.
3. Any Attorneys fees and costs incurred by Independent Drug Testing Supply to collect past due balances will be paid by Company
4. The undersigned hereby authorizes and instructs the above-mentioned banks to release the information requested by Independent Drug Testing Supply.

The undersigned authorizes inquiry as to credit information.

Signature on behalf of Company: _____ Date: _____

Print Name: _____Title: _____

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LIST APPLICABLE TRADE REFERENCES BELOW:

4. **Company Name:** _____ **Contact Name:** _____
   Phone: (_____) _____ Fax: (_____) _____
   Account Number: _____

5. **Company Name:** _____ **Contact Name:** _____
   Phone: (_____) _____ Fax: (_____) _____
   Account Number: _____

6. **Company Name:** _____ **Contact Name:** _____
   Phone: (_____) _____ Fax: (_____) _____
   Account Number: _____

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3. Any Attorneys fees and costs incurred by Independent Drug Testing Supply to collect past due balances will be paid by Company
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The undersigned authorizes inquiry as to credit information.

Signature on behalf of Company: _____ Date: _____

Print Name: _____Title: _____

Please return you application by US mail to:
Independent Drug Testing Supply
9701 Research Drive, Ste 100
Irvine, CA 92618
Attention: Accounting Department

Or you may fax the application to:
(714) 962-6781