



**KARMAN HEALTHCARE INC.**  
 19255 San Jose Ave. City of Industry, CA 91748  
 Tel: 626-581-2235 Fax: 626-581-2335

*To be eligible to purchase as a dealer please fill  
 this side out and send in to our fax.*

**DEALERSHIP APPLICATION**

Company Name: \_\_\_\_\_ Tel: \_\_\_\_\_ Fax: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ E-mail: \_\_\_\_\_

Sales Contact: \_\_\_\_\_ Payment Contact: \_\_\_\_\_

Type of Business: \_\_\_\_\_ Sole Ownership \_\_\_\_\_ Partnership \_\_\_\_\_ Corporation

Years in Business: \_\_\_\_\_ **Valid Seller's Permit No.:** X \_\_\_\_\_

Names of Principals:

Name: \_\_\_\_\_ Title: \_\_\_\_\_ **SS#:** X \_\_\_\_\_

Address: \_\_\_\_\_

Name: \_\_\_\_\_ Title: \_\_\_\_\_

Address: \_\_\_\_\_

**Bank Reference**

Bank: \_\_\_\_\_ Branch: \_\_\_\_\_ Contact: \_\_\_\_\_

Bank Account #: \_\_\_\_\_ Tel: \_\_\_\_\_

**Trade Reference**

Company Name

1) \_\_\_\_\_ Address: \_\_\_\_\_

Account# : \_\_\_\_\_ Tel: \_\_\_\_\_ Fax: \_\_\_\_\_

2) \_\_\_\_\_ Address: \_\_\_\_\_

Account# : \_\_\_\_\_ Tel: \_\_\_\_\_ Fax: \_\_\_\_\_

3) \_\_\_\_\_ Address: \_\_\_\_\_

Account# : \_\_\_\_\_ Tel: \_\_\_\_\_ Fax: \_\_\_\_\_

D&B No. (If Any) : \_\_\_\_\_

To induce you to accept our credit for purchases under your credit sale terms, we authorize you to contact the references given above (including our bank) to obtain sufficient and satisfactory credit information. In the event of default of payment when due, we agree to pay all cost of collection, including attorney's fees, court costs, and collection agency fees and pay interest on all past due balances, at the rate of 1.5% per month, or the maximum legal rate, whichever is lower. I personally guarantee the payment. We also agree to pay \$15 for each check returned to KARMAN without payment.

**Authorized Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Print Name:** \_\_\_\_\_ **Title:** \_\_\_\_\_