



Karman Healthcare Excellence Through Mobility™

Please fax or email your completed account application to:

CREDIT DEPARTMENT

FAX: (626) 581-2335

Email: ada@karmanhealthcare.com

*Be Sure to Include Your State Specific Resales Certificate and Your Sales Representatives Name (if known) on the Application *



To be eligible to purchase as a dealer please fill this side out and fax us

KARMAN HEALTHCARE, INC.
19255 San Jose Avenue
City of Industry, CA 91748

www.karmanhealthcare.com

Tel: 626-581-2235 Fax: 626-581-2335

DEALERSHIP APPLICATION

Legal Name of Business: DBA(if different):
Address: City: State: ZIP:
Tel: Fax: Website:
Federal Tax ID#: Valid Seller's Permit#:
Type of Business: Solo Ownership Partnership Corporation Other
D&B Number: Employees:
Property: Owned Leased Other Years in Business:

Send fax original copy of your Resale Certificate as confirmation

Names of Principals:

Name: Title: SS#:
Address:
Name: Title: SS#:
Address:

Contact Information

Purchasing Contact: Email:
Tel: Fax:
AP Contact: Email:
Tel: Fax:

I want my Monthly Statement/Invoice Emailed to:

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:

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:



KARMAN HEALTHCARE INC.
TERMS & CONDITIONS OF SALES

Shipping and Handling:

Karman Healthcare Inc. will prepay shipping and handling charges and add them to your invoice. All orders are shipped by the appropriate courier service, according to the type of unit, quantity ordered and best freight quote.

--Special Shipping Services—

We offer the following special optional shipping services:

(please email- orders@karmanhealthcare.com for quote or confirmation)

- Signature Verification
- Expedited Shipping
- Shipping outside 48 contiguous states/international shipments
- Insured Shipping

Payment Terms:

New customers must prepay by check or credit card until credit can be established and the *terms and conditions* form has been signed and returned to Karman. We reserve the right to deny credit or withdraw credit terms for delinquent accounts. Late fees will be added to all invoices that are past due. Terms are Net 30 days upon credit approval. Interest charges of 1.5% per month will apply to all past due accounts. Past due accounts will not be eligible for monthly specials. In the event that any third parties are employed to collect any outstanding balance, the purchaser is responsible for any collections costs, including attorney’s fees, whether or not litigation has commenced, and all cost of litigation incurred. Credit card on file will also be a form a payment to be charged should any account be deemed past due. Pre-paid designated units must be paid complete prior to shipping. A 3.5 percent charge may be applied if paid with credit card.

Return Policy:

Return authorization must be obtained in advance from Karman. No return of any kind will be accepted after fourteen (14) *calendar* days from the invoice date and shipped back within 30 days shipped freight prepaid. Goods accepted for credit upon return will be subject to a 15% handling/restocking charge and all transportation charges must be prepaid. For orders being returned for exchange in color, size, etc. the restocking fee will be reduced to 10%.

Custom-made goods are not subject to return under any circumstances. In no case are goods to be returned without first obtaining an R.M.A number (Returned Merchandise Authorization). Return authorization number must be marked on the outside of the box and ship back to Karman. All freight charges including the 1st way from Karman to the customers will not be credited or refunded.

Damage Freight Claims:

Examine and test all shipments upon delivery. No product with damage/defect will be accepted back after 5 days of receipt. Visible damage and/or carton shortage must be noted on the carrier’s delivery receipt and/or packing list.

Warranties:

Please refer to the warranty card attached to each product for more information on policies and procedures. All warranty repairs or replacements must have prior authorization from Karman with freight prepaid. Karman will not issue call tags for any warranty repairs.

Marketing:

Companies must have approval by Karman Healthcare Inc. to market products online or through mailed catalog promotion. At any time Karman Healthcare Inc. has the right to revoke marketing privileges to any company. Once revoked, the company must remove all Karman products on purchasing listings as the company and Karman Healthcare Inc. will no longer have further business relations. All dealers should comply with our MAP (minimum advertised pricing) policy.

FDA Regulations:

Companies must comply with FDA regulations while sale tracked medical device. (Sec. 821.30 Tracking obligations of persons other than device manufacturers: distributor requirements.)

<p>Authorized Signature: _____ Date: _____</p> <p>Print Name: _____</p>
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KARMAN HEALTHCARE INC.

19255 SAN JOSE AVE.
CITY OF INDUSTRY, CA 91748
Tel: 626-581-2235 • Fax: 626-581-2335

CREDIT CARD AUTHORIZATION FORM

I AUTHORIZE KARMAN HEALTHCARE INC. TO CHARGE MY CREDIT CARD FOR THE FEES AS INDICATED BELOW.

DATE: ____ / ____ / ____

COMPANY NAME: _____

CREDIT CARD TYPE: () VISA () MASTERCARD () AMERICAN EXPRESS

CARD NUMBER: _____

Validation Code: _____ (Visa/MasterCard – the 3-digit number on the back of the card on the signature space. American Express – the 4-digit number that immediately follows the card number). Karman is authorized to charge any past due balances with this account.

EXPIRATION DATE: _____ / _____

AMOUNT: _____, _____ . _____

(PRINT) CARD HOLDER'S NAME:

CARD HOLDER'S SIGNATURE:

CARD STATEMENT MAILING ADDRESS:

REMARKS: _____

