#2A-2054 Kingsway Ave
Port Conquitlam, BC V3C 1S5
info@smartmovemedical.com

Credit Application Form

BUSINESS CONTACT INFORMATION

Title		Date business commenced	
Company name		☐ Sole proprietorship	
Phone | Fax		☐ Partnership	
E-mail		☐ Corporation	
Registered company address City, State ZIP Code		☐ Other	

BUSINESS AND CREDIT INFORMATION

City, State ZIP Code		Bank name:	
How long at current address?		Primary business address City, State ZIP Code	
Phone		Phone	
Fax		Account number	
E-mail		Type of account	☐Savings ☐ Checking ☐ Other

BUSINESS/TRADE REFERENCES

Company name		Phone	
Address		Fax	
City, State ZIP Code		E-mail	
Type of account		Other	
Company name		Phone	
Address		Fax	
City, State ZIP Code		E-mail	
Type of account		Other	
Company name		Phone	
Address		Fax	
City, State ZIP Code		E-mail	
Type of account	☐Savings ☐ Checking ☐ Other	Other	

AGREEMENT

1. All invoices are to be paid 30 days from the date of the invoice.
2. Claims arising from invoices must be made within seven working days.
3. By submitting this application, you authorize [Company Name] to make inquiries into the banking and business/trade references that you have supplied.

SIGNATURES

Signature		Signature	
Name and Title		Name and Title	
Date		Date	