GROVE MEDICAL, INC.
APPLICATION FOR CREDIT

Salesperson's Name: _____
Date Received: _____
Customer No. Assigned: _____

Legal Company Name: _____ Federal ID No.: _____
D.B.A.: _____ Year Business Started: _____
Address: _____ Years at Present Location: _____
_____ County: _____
City: _____ State: _____ Zip Code: _____
Shipping Address: _____
City: _____ State: _____ Zip Code: _____
Purchasing Contact: _____ Email Address: _____
Phone: _____ Fax: _____
Would you like to be set up for Online Ordering? Yes □ No □
A/P Contact: _____ Email Address: _____
Phone: _____ Fax: _____
Tax Status: □ Taxable □ **Resale ** □ **Exempt Organization****

****A RESALE/EXEMPT CERTIFICATE MUST BE RETURNED WITH COMPLETED APPLICATION IN ORDER TO HAVE EXEMPT STATUS****

Form of ownership: □ Partnership □ Corporation □ Proprietorship
Type of Business:
□ Long-Term Care □ Assisted Living □ DME
□ State/County □ Physicians □ Non-Profit
□ Home Health □ Other: _____
Purchase Order Required: □ Yes □ No Annual Sales: $_____
If a Parent Company Exists: □ Division □ Subsidiary
Name of Parent Company: _____
Address: _____
City: _____ State: _____ Zip Code: _____

If a Long-Term Care facility or Assisted Living Facility:
Management Company Name and Address: _____
Of beds in the facility_____

Owner's	Partners'/Officers' Name	Address	SS#	Official Title

BANKING REFERENCES (INCLUDE ACCOUNT NO. AND CONTACT)

Type of Account: □ Checking □ Savings Account No.: _____
Name and Address: _____
Type of Account: □ Checking □ Savings Account No.: _____
Name and Address: _____

CREDIT REFERENCES (COMPLETE INFORMATION MUST BE FURNISHED)

Vendor Name	Address	City/State/Zip	Phone No.	Fax No.

CREDIT LIMIT REQUESTED: $_____.00

****PLEASE ATTACH A CURRENT AUDITED FINANCIAL STATEMENT****

FAX COMPLETED CREDIT APPLICATIONS TO 864-220-1745
MAIL ORIGINALS TO GROVE MEDICAL, INC. 1089 PARK WEST BLVD., GREENVILLE, SC 29611 ATTN: CREDIT DEPT.

GROVE MEDICAL, INC.
TERMS OF SALE

Applicant's Name: _____

1. Payment for products purchased from Grove Medical, Inc. is due 30 days from the date of the invoice. Payments should be mailed to 1089 Park West Blvd, Greenville, SC 29611.
2. Past due balances will be subject to a service charge of one and one half percent (1.5%) per month or the maximum charge permitted under applicable law, whichever is less.
3. If the account is placed for collection, the undersigned agrees to pay all costs and expenses of collection including reasonable attorney's fee and expenses. The undersigned agrees and consents to the exclusive jurisdiction and venue in the federal and state courts located in the County of Greenville, State of South Carolina and specifically waives any objection to such jurisdiction or venue.
4. To secure payment for all purchases from Secured Party, now and in the future, the undersigned hereby grants Secured Party a continuing security interest in all of the undersigned's presently owned or hereafter (a) goods, (b) instruments, (c) Chattel paper, (d) books and records, (e) accounts, (f) accounts receivable, (g) general intangibles, and (h) payment intangibles and together with all proceeds and all support obligations thereof. The following constitute Customer defaults: Non-payment in timely fashion of Customer's indebtedness to Grove Medical, Inc, bankruptcy, insolvency, or assignment for the benefit of creditors, misrepresentation in respect of any provision of this or any Agreement between Grove Medical, Inc and Customer. In the event of default Grove Medical, Inc may declare all unpaid balances due. Customer authorizes Secured Party to file a financing statement describing the collateral.
5. The undersigned agrees to notify Grove Medical, Inc. by certified mail of any change in ownership of the customer and further agrees to be liable for all purchases should the undersigned fail to comply with said notification.
6. The undersigned hereby authorizes Grove Medical, Inc. to contact and investigate the references including the banks listed on page 1, and the undersigned authorizes the references to release the requested information.

Name: _____ Title: _____
(PLEASE PRINT) (PLEASE PRINT)

*Authorized Signature: _____
(* PERSON MUST BE AUTHORIZED TO CONDUCT BUSINESS OF BEHALF OF THE ENTITY APPLYING FOR CREDIT)

Personal Guarantee for: _____
(Applicant's Company Name)

The undersigned guarantees payment of all indebtness incurred by the above applicant to Grove Medical, Inc. whether now due or hereafter incurred. This payment will be made in South Carolina at the offices of Grove Medical, Inc. The undersigned also agrees to pay to Grove Medical, Inc. reasonable attorney's fees incurred in the collection of such indebtedness. It shall not be necessary for Grove Medical, Inc. in order to enforce the obligations of the undersigned hereunder, to first institute suit or pursue or exhaust its remedies against the applicant. If more than one individual signs, below, each shall be liable hereunder jointly and severally. The undersigned agrees and consents to the exclusive jurisdiction and venue in the federal and state courts located in the County of Greenville, State of South Carolina and specifically waives any objection to such jurisdiction or venue. The guarantee shall remain in full force and effect until released by Grove Medical, Inc. in writing or until notice is received by Grove Medical Inc. from the undersigned, although such notice by the undersigned shall apply only to indebtedness arising thereafter and shall not affect the guarantee or indebtedness then existing. Please note that a signature followed by a corporate title invalidates the personal guarantee.

Dated: _____ Signature: _____

Dated: _____ Signature: _____

To purchase medications and injectables, please provide a physician signature and DEA No.:

Signature: _____ DEA No.: _____

FAX COMPLETED CREDIT APPLICATIONS TO 864-220-1745
MAIL ORIGINALS TO GROVE MEDICAL, INC. 1089 PARK WEST BLVD., GREENVILLE, SC 29611 ATTN: CREDIT DEPT.

Grove Medical, Inc.

Customer Delivery Profile

In an effort to better meet your delivery needs, we ask that you please take a moment to fill out the following information. This will help ensure that we are providing the best possible service to you and your facility. Thank you.

Date: _____ Sales Rep: _____

Account Name: _____ Account Number: _____

Contact for Deliveries:_____ Contact Phone _____

Delivery Address:_____ City: _____

State: _____ Zip: _____

Receiving Hours: _____ Receiving Dock: Yes_____ No_____

If no, do you have a ramp/entrance to accommodate a pallet jack? _____

If no, do you require a lift gate? _____

Receiving in located: Front_____ Rear_____ Other_____

Deliveries made: Ground Level _____ Upstairs_____ Other_____

Do deliveries require an appointment? Yes_____ No_____ If Yes, please provide phone number and

contact name _____

***Delivering carrier may charge additional cost for appointment deliveries and will delay your shipment a minimum of 1 day**

Will delivery be affected by narrow hallways or doorways? _____

Will delivery be affected by low ceilings? _____

Will a 53 foot trailer have direct access to the building? Yes _____ No _____ Other_____

If No, is 48 foot required or a straight truck? _____

***If a straight truck is required this could delay shipment by minimum of 1 day.**

Are there multiple locations at your facility for deliveries: Yes_____ No_____ If yes, are there additional addresses and deliveries: _____

Are there other special requirements/instructions for delivery? _____