



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: _____

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 also agrees and consents that in the event litigation becomes necessary the laws of the State of South Carolina shall govern.
4. 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.
5. 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 indebtedness 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 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.



Customer Delivery Profile

Account Manager: _____ Date: _____

Account Name: _____ Account Number: _____

Contact for Deliveries: _____

Contact Phone Number: _____

Delivery Address: _____

Will you accept subs: Yes _____ No _____

Frequency of Deliveries: Weekly _____ Bi-Weekly _____ Monthly _____ As Needed _____

Preferred day for delivery: (circle one) Monday Tuesday Wednesday Thursday Friday

Comments: _____

Receiving Hours: From _____ To _____ (Example 8:00 AM to 4:00 PM)

Do you have a Receiving Dock: Yes _____ No _____

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

Can a 53 trailer access your site for delivery? Yes _____ No _____

Receiving is located: Front _____ Rear _____ Side _____

Deliveries made: Ground Level _____ Upstairs _____ Downstairs _____

Are there Multiple Locations at your facility for deliveries: Yes _____ No _____ (I.E. Front & Rear Delivery)

If so, additional addresses: _____

Do you require a call before delivery: Yes _____ No _____ (a call or appointment may delay shipment 1 day)

If so, what is the phone number: _____ Contact Name: _____

Average order size: Large= 4+ pallets _____ Medium= 2-3 pallets _____ Small= 1 pallet or less _____

Any special requirements for your deliveries: _____

Return to: Michael Laico – Fax # 864-220-1745 or email Michael@grovemedical.com