Account Application

Application must be completed and signed, with order attached, to initiate processing.

NAME Madison County, MS Parent or Subsidiary of _____

Do you or parent have an existing acct. #: ☐ Yes ☒ No If yes, please provide acct. #: _____

Headquarters Location Canton, MS Are you a distributor: ☐ Yes ☒ No

Billing Address PO Box 608

City Canton County Madson State MS Zip 39046

Shipping Address 146 W Center St

City Canton County Madison State MS Zip 39046

Phone Number w/Area Code: (601-855-5502) 601-855-5502 Fax Number w/Area Code: (601-855-5502) 601-859-5875

Amount of Credit Line Requested: $ 2,000.00 Date Business Started: 1824

Are Vouchers Required for Payment: ☐ Yes ☒ No If yes, please submit with orders. D & B #: 884388737

STATE SALES TAX EXEMPT: ☒ Yes ☐ No **If yes, you must provide DXE Medical with a copy of your tax exemption certificate to avoid being charged taxes.**

NAME AND TELEPHONE OF PERSON RESPONSIBLE FOR ACCOUNTS PAYABLE:

Name Shelton Vance Phone # 601-855-5502 Fax # _____ Email: comptroller@madison-co.com

SHIPPING: Complete Only ☐ Partial Shipment Okay ☒ Are PO's Required ☒ Yes ☐ No

The following persons are authorized to purchase from this account:

1. Name Hardy Crunk Title Purchasing Director
2. Name Tom Lariviere Title Fire and EMS Coordinator
3. Name _____ Title _____

REFERENCES (MAJOR SUPPLIERS)

1. Major Supplier Name ADCAMP Account# MADCTY
   Phone Number w/Area Code (601-939-4493) Fax Number (601-939-4676) Email mollie@adcampinc.com
   Address _____ City _____ State _____ Zip _____
2. Major Supplier Name _____ Account# _____
   Phone Number w/Area Code ( ) Fax Number ( ) Email _____
   Address _____ City _____ State _____ Zip _____
3. Major Supplier Name _____ Account# _____
   Phone Number w/Area Code ( ) Fax Number ( ) Email _____
   Address _____ City _____ State _____ Zip _____

This information is warranted to be true and is given for the purpose of obtaining credit from DXE Medical. I (we) agree to pay all bills for purchases net 30 days from the date of invoice. Should legal action be instituted to enforce payment of any outstanding balance, I (we) agree to pay all costs of suit and reasonable attorney's fees.

Signature X _____

Print Name & Title _____ Date _____

Please email the completed form to: sales@dxemed.com

or Fax to: **Toll Free** 844-318-0590
Local 614-760-5330

Payment Remittance Address: DXE Medical, Inc.
Attn: Accounts Receivable
PO Box 8023
Dublin, OH 43016

For Internal Use Only

Approved By _____

Date Approved _____ Terms _____ Limit _____