DAVID HEALTH INTERNATIONAL

Please fill out this form
and Fax or email to the office

New Account Application

1111 Flint Rd. Unit 25, North York, ON M3J 3C7
Tollfree: 1-855-387-1010
Office: 1-647-726-1010
FAX: 1-416-679-0031

Business Information

*** To expedite your account application, please provide a copy of your credentials.**

Legal Business Name: **Main contact Name / title :** /

Trade (Store) Name:

No. of years in business: **Type of business:** ☐ Retail ☐ Practitioner ☐ Other( )

Business No. : **PST No. (Where applicable):**

Billing Address: (Street) (City)

(Province/ Postal Code) / (Phone) (Fax)

Shipping Address: (Street) (City)

(Province/ Postal Code) / (Phone) (Fax)

Billing Preference: **Terms*** ☐ **Credit Card** ☐ **C.O.D** ☐

Select Shipping Preferences: ☐ Direct Delivery ☐ Courrier (UPS) ☐ Canada Post ☐ Logistic Service

* Please Advise that the first two orders should be paid by credit card. The additional credit application has to be approved for term payment option. All orders must be prepaid or shipped C.O.D. until credit has been approved.

Credit & Bank Information

Name of Bank: **Branch:**

Bank Address:

(City) (Province/ Postal Code) /

Account No. : **Phone:**

Trade Reference

Company Name:1

Contact Name 1:

Phone / Ext. 1: (ext.)

Company Name:2

Contact Name 2:

Phone / Ext. 2: (ext.)

Credit Card Authorization

I / We authorize David Health International to charge **my / our / company** credit card to any outstanding debts of purchases that customer / applicant may make.

Credit Card No. : ☐ VISA ☐ MASTER ☐ AMEX

Name on the Card: Expire on (mm/yy): /

CVC/CVV:

Signature of applicant: Date:

* Applicant's agreement

I/We authorize David Health International to conduct any lawful investigation as may be required to gather the information necessary to approve credit terms for my/ our business/company. **I / We** agree to make payment in accordance with **David Health International's term and** authorize David Health International to charge **my / our / company** credit card to any outstanding debts of purchases **I/We** may make. **I/We** have provided correct information above and have the authority to bind the **business/company** to this agreement. **I/We** agree to C.O.D. or PMT. IN ADV. terms for the orders until credit is approved.

I understand that data collected in this application will be stored in a database that David Health International may use in the future to provide me/us with online services. By providing an email address, I/we allow David Health International to a) send notices and advertisements in electronic form to my/our email and b) register me/us at the website, http://www.davidwholesale.com , in which I/we may receive latest news and will be able to place online orders.

Email Address **Applicant's Signature**

Applicant's Name **Date**

* Interest at the rate of 2% per month is charged on all past due balances. In the event the account is delinquent and satisfactory arrangements have not been made for payment, all legal fees, attorney fees and collection will be assumed by the debtor.

<Office Use Only> Account No.: Rep: