Business Credit Application

General Information

Legal Business Name: ____

Doing Business As: ____
Address: ____
City/State/zip ____
Phone __________ Fax ____________ Email ______________________________
Account Payable Contact ______________________ Phone __________________________
Accounts Payable email ____
Billing Information (if different than above)
Address: ____
City/State/zip ____

Business Characteristics

Business Type ◻ Individual ◻ Corporate ◻ S-Corp ◻ Partnership
◻ Other _______________ Business Start Date ____________________________
Tax Payer ID# ____________________________

Principals

List Majority Principals, or Company Directors (may include separate sheet)
Full Name ____
Home Address ________________________ Phone ______________________________

Bank and Trade References

Bank Name ___________________________ Phone ______________________________
Bank contact ___________________________ Email ______________________________

List three Trade References, address, and phone, years doing business

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Personal Guaranty

For accounts requesting Credit Balance greater than $5,000, Personal Guaranty must be signed by authorized representative. See attached third page.

Requested Credit line $_______________ Payment terms net 30

I hereby certify that the information contained herein is complete and accurate. I am authorized representative to bind our business entity. This Information has been furnished with the understanding that it will be used to determine the amount and conditions of credit to be extended. Furthermore, I hereby authorize the financial institutions listed to release necessary information to Salcido Family Medicine for which credit is being applied for. I have fully read and accept the attached terms and conditions.

In the event of default, we may demand that the entire unpaid balance be paid immediately. If we refer your account to an attorney, we will charge you the cost associated with collection on account. If payment is not received within due date, late charge of $30 may be assessed. If payment is not received after 30 days of payment due date, interest of 18% may be assessed.

____
Print Name

_________________________________Date _______________
Signature

Personal Guaranty

In consideration to Salcido Family Practice granting extending credit to the business identified below for services at the request of applicants or its agents the undersigned individual hereby personally guarantees unconditionally and any sums now or hereafter owed to Salcido Family Medicine by the business identified below whether said sums are due under open account, contract or otherwise.
It is understood and agreed that credit, if extended is to be on a continuing basis and may exceed estimated maximum credit limit required as stated in the credit agreement between Salcido Family Practice and by the business. Salcido Family Medicine shall not be obligated to notify the undersigned of the date or amounts of any such credit and the undersigned waives demand, notice of default and any extension of time or any forbearance which may be extended by Salcido Family Medicine.
This guaranty shall continue in force until notice in writing, sent by registered or certified mail, return receipt requested by Salcido Family Medicine. Said notice shall specify the date on which the guaranty is to be terminated, said date not be less than fifteen working days after such notice is received.

Date: ________________ Name ____
(Print Name above of person guaranteeing payment)
(May only be signed by individual authorized to bind company)

Home Address________________________
Cell Phone___________________________

Signature of Guarantor

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