



LYNN MEDICAL®

New Account Application

CUSTOMER NAME _____

PHONE _____

BILLING ADDRESS _____

FAX _____

SHIPPING ADDRESS _____

CONTACT _____

REQUIRED: Federal Tax ID #

How long has business been established?

Is business tax exempt?

How long at this location?

If yes, please attach exemption certificate.

REFERENCES

BANK NAME	ACCOUNT NUMBER (required by most banks)
STREET ADDRESS	PHONE NUMBER & PERSON TO CONTACT
CITY, STATE, ZIP	FOR LYNN MEDICAL USE::
CHECKING <input type="checkbox"/> LOANS <input type="checkbox"/>	

SUPPLIER NAME	ACCOUNT NUMBER
STREET ADDRESS	FOR LYNN MEDICAL USE::
CITY, STATE, ZIP	
PHONE NUMBER	
FAX NUMBER	

SUPPLIER NAME	ACCOUNT NUMBER
STREET ADDRESS	FOR LYNN MEDICAL USE::
CITY, STATE, ZIP	
PHONE NUMBER	
FAX NUMBER	

INVOICE RECIEPT METHOD

Fax

E-Mail

A/P Manager –Name

Phone

Fax#

E-Mail

Lynn Medical standard terms of payment: 30 days net

All shipments: F.O.B. Shipping Point

A finance Charge of 1.5% per month applies to all past due invoices.

CUSTOMER SIGNATURE	DATE
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