

# Credit Application

## BUSINESS TYPE:

Hospital     Clinic     School/Government     HA Dispensary     Distributor     Hospital w/ Clinic     Other

## ESTIMATED ANNUAL PURCHASES:

<\$3,000     \$3,000 – 10,000     \$10,001 – 50,000     \$50,001 – 100,000     >\$100,000

INITIAL ORDER DATE: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

## BILL TO ADDRESS:

Business Name(DBA): \_\_\_\_\_ Phone: \_\_\_\_\_  
Legal Name: \_\_\_\_\_ Fax: \_\_\_\_\_  
Street Address: \_\_\_\_\_ Website: \_\_\_\_\_  
City, State, Country & Zip: \_\_\_\_\_

## SHIP TO ADDRESS:

Business Name (DBA): \_\_\_\_\_ Phone: \_\_\_\_\_  
Street Address: \_\_\_\_\_ Fax: \_\_\_\_\_  
City, State, Country & Zip: \_\_\_\_\_ UPS/FedEx #: \_\_\_\_\_

IS YOUR BUSINESS TAX EXEMPT?     Yes     No

Important: If your business is tax exempt, you must fax a tax exempt certificate to Cochlear at (303) 524-6781 with your credit application. Tax law requires Cochlear to collect and remit tax on all taxable sales until this documentation is on file.

## INTERNAL CONTACTS:

### Accounts Payable Contact:

Name (Last): \_\_\_\_\_ (First): \_\_\_\_\_ Phone: \_\_\_\_\_  
E-mail: \_\_\_\_\_ Fax: \_\_\_\_\_

### Purchasing Contact:

Name (Last): \_\_\_\_\_ (First): \_\_\_\_\_ Phone: \_\_\_\_\_  
E-mail: \_\_\_\_\_ Fax: \_\_\_\_\_

## DISCLAIMER:

I hereby certify that the information contained herein is complete and accurate. This information has been furnished with the understanding that it is to be used to determine the amount and conditions of the credit to be extended by Cochlear Americas.

## SIGNATURE:

Signature: \_\_\_\_\_ Print Name: \_\_\_\_\_  
Title: \_\_\_\_\_ Date: \_\_\_\_\_

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## PRINCIPALS IN THE BUSINESS:

Name: \_\_\_\_\_ Title: \_\_\_\_\_ Phone: \_\_\_\_\_  
Name: \_\_\_\_\_ Title: \_\_\_\_\_ Phone: \_\_\_\_\_

## REFERENCES:

### BANK REFERENCES:

Business Name: \_\_\_\_\_ Contact Name: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone: \_\_\_\_\_

### TRADE REFERENCES:

Business Name: \_\_\_\_\_ Contact Name: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Business Name: \_\_\_\_\_ Contact Name: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Business Name: \_\_\_\_\_ Contact Name: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Please allow one to two business days for processing..

[www.cochlear.com](http://www.cochlear.com)

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