PHS

Premium Health Services, Inc.

Your full service pharmaceutical supplier

CREDIT APPLICATION

Legal Name:	Trade Style (or DBA)
Federal ID No:	Taxable____Y ___N (Attach Certificate)

Billing Address	Shipping Address
Street Number:	Street Number:
City: State: Zip:	City: State: Zip:

Accounting Phone:	Accounting Contact:	Facility Phone:	Facility Contact:

Is your business a member of a GPO? _____ If so, which GPO?

BANK REFERENCES		
Bank / Branch:	Account No:	Phone: Contact:
Bank / Branch:	Account No:	Phone: Contact:

Please list current suppliers you have purchased from:		
Supplier: Phone: Contact: Account No:	Supplier: Phone: Contact: Account No:	Supplier: Phone: Contact: Account No:

Assignment: By signing this credit application I hereby authorize the release of any required credit information to PHS from banks, national credit reporting agencies, commercial or consumer related.

Signature: _____ Print Name: _____ Date: _____

Estimated monthly purchases from PHS: _____

Medical facilities not required by state or federal law to possess any form of regulatory license, registration or permit to operate your business must provide a copy of a physician's license, registration or permit who will be responsible for the receipt of and accountability of pharmaceutical products.

State license required for all accounts.

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