DEAL MEDICAL AND SAFETY SUPPLY

Corporate Office
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Mailing Address
PO Box 630067, Houston, TX 77263-0067

Tel *(713) 777-1155* *info@dealmedical.com*
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CREDIT CARD APPLICATION AND AGREEMENT FORM

Practice Name

Contact Person

Address

City *State* *Zip*

Tel *Fax*

Email *Web*

Physician Full Name

State License (Please attached copy)
Number Expiration

Practice Business Legal Name

Type of Business
☐ Corporation ☐ Partnership ☐ Sole Proprietor ☐ Other ____

Name of Credit Card Holder

Credit Card Information

- ☐ VISA ☐ MasterCard
- ☐ Number _____ - _____ - _____ - _____
- ☐ Expiration _____ / _____

Applicant's Statement – I authorize Deal Medical and Safety Supply to charge the above credit card with the amount of my purchase. In the event my/our company defaults payment of bills and is turned for collections, my/our company shall be fully liable for any fees and sums charged by the collection agency or attorney. If any suit or other judicial proceeding is instituted or is collected through or bankruptcy proceeding, my/our company will be fully liable for all attorney fees and court cost incurred by Deal Medical and Safety Supply in the collection of said bills.

Name of Card Holder ***Signature***

Title ***Date***

I authorize the persons listed below to receive and sign orders from Deal Medical and Safety Supply and which are charged to the above credit card.

Full Name ***Signature***

Full Name ***Signature***

Full Name ***Signature***