



CREDIT APPLICATION

COMPANY NAME: _____

Street _____ City _____ Province _____

Postal Code _____ Telephone No. _____ Fax No. _____

SHIPPING ADDRESS: (If different from Billing Address Above): _____

Street _____ City _____ Province _____

Postal Code _____ Telephone No. _____ Fax No. _____

TRADE REFERENCES (Other Fine Chemical Suppliers):

	Name:	Address:	Telephone #:	Fax#:
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____

FINANCIAL INSTITUTION DETAILS

Name of Institution _____

Street _____ City _____ Province _____

Account Number _____

Contact Name: _____

Fax Number: _____

Telephone: _____

REQUIRED CREDIT LIMIT _____

The following statement requires the applicants signature:
I hereby consent to routine credit verification by Almat Pharmachem Inc.

_____ Authorized Signature _____ Date

TERMS: NET 30 DAYS, unless otherwise specified in writing.
A monthly service charge of 1.5% will be applied on all overdue amounts.

RETURN COMPLETED FORM TO: ALMAT PHARMACHEM INC.
Attention: Customer Service
57 Corstate Ave. Suite 200
Concord, Ontario, L4K 4Y2
Fax Number: 905-761-8440

Sales Rep: _____