ABO Pharmaceuticals New Account / Credit Application

Please read all information carefully

1. Account Information

Legal business name _____

Main phone _____ Fax _____

Billing address _____

City _____ State _____ Zip _____

Purchasing contact _____ Phone _____

Purchasing contact email _____

A/P contact name _____ Phone _____

A/P contact email _____

DUNS # _____

☐ Corporation ☐ Partnership ☐ Proprietorship
☐ Franchisee ☐ LLC ☐ 501C3 (non-profit)

2. Delivery Information Address

Delivery address _____

City _____ State _____ Zip _____

Phone _____ Fax _____

Contact name _____

3. Credit Card Payment

Credit Card Name _____

Credit Card Number _____

CC Exp _____ CC Security Code _____

Billing address : _____

Billing address : _____

Credit Card Signature On File :

4. Pharmaceutical Credit References

Name _____ Account no. _____
How long? _____ Contact name _____
City _____ State _____ Zip _____
Phone _____ Fax _____

Name _____ Account no. _____
How long? _____ Contact name _____
City _____ State _____ Zip _____
Phone _____ Fax _____

Name _____ Account no. _____
How long? _____ Contact name _____
City _____ State _____ Zip _____
Phone _____ Fax _____

5. Estimated Monthly Purchase

(please check the appropriate box)

☐ $0 - $5,000 ☐ $5,001 - $10,000
☐ $10,001 - $20,000 ☐ $20,001 - $40,000
☐ $40,001 + (may require financials)

Is your business part of a GPO (Group Purchasing Organization)? ☐ Yes ☐ No

If Yes, which affiliation(s)? _____

_____

Facility type to which product will be shipped

(please check the most applicable):

☐ Doctors Office ☐ Long-term care
☐ Hospital outpatient clinic ☐ Open door pharmacy
☐ Wholesaler/Distributor ☐ Closed door pharmacy
☐ Community Vaccinator ☐ Industrial
☐ Physician – specialty:
☐ Clinic – specialty:
☐ Other – please specify:

If you require multiple ship-to addresses, please attach a separate sheet with shipping address and acceptable licensing for each facility.

7. Acceptable Licensing

Federal and state laws require ABO to verify proper licensing to purchase prescriptions or products labeled "Rx Only."

Please fax license(s) with application to:
877-718-0118

License Type:	
License No.:	
Exp. Date:	

Please sign Terms and Conditions on page 2

Official Use Only				
Date:	Time:	Credit limit:	Account credit checked by:
Date:	Time:	Order pending:	Account set up by:

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Terms and Conditions

You agree that the information is current, correct and accurate according to the best of your knowledge. I agree to notify ABO Pharmaceuticals immediately and in writing of any change in ownership, change in the nature of the business, name, location or financial condition. ABO Pharmaceuticals may limit or discontinue any credit at its sole discretion at any time. I authorize ABO Pharmaceuticals to verify any information contained in this application. Applicant agrees to pay in a timely manner in accordance to the terms of sale. In any litigation arising out of, or related to amounts due, ABO Pharmaceuticals, the prevailing party shall be entitled to its reasonable attorney's fees, expert witness fees and cost. This agreement shall be construed according to California Law and venue shall be in San Diego, California.

Please send payments to:

ABO Pharmaceuticals
7930 Arjons Drive, Suite A
San Diego, Ca 92126

Terms of payment for all orders are Net 15 or Net 30 based on ABO sole credit decision. All Payments are due on date of invoice, unless otherwise agreed to by customer and ABO Pharmaceuticals.

Please sign and FAX to: 877-718-0118

I hereby warrant and represent that ABO Pharmaceuticals has the authority to bind the Customer to the terms and conditions stated above. Furthermore, the Customer agrees to comply with all conditions stated above and to authorize the release of credit information to ABO Pharmaceuticals

Authorized purchasing agent signature (for legal account name)	Print name and title
Date	Legal account name of facility

ABO Pharmaceuticals
Your Unmatched Distribution Channel

got flu?