



GF HEALTH PRODUCTS, INC.

2935 Northeast Parkway • Atlanta • Georgia 30360

Phone: 800.347.5678 • 770.447.1609 • Fax: 800.479-0822 • 678.291-3174

www.grahamfield.com

To:		Date:	
From:		To Fax:	
Phone:	800-347-5678	Pages:	3
Fax:	678-291-3174	Copy:	
Re:	Credit Application / New Account		

Comments:

VERY IMPORTANT: MUST COMPLETE ALL AREAS TO AVOID DELAY OF NEW ACCOUNT PROCESS!

Attached is our credit application as requested. Please complete all areas and return it back via fax to 678-291-3174. We must receive a copy of your company's Resale Certificate in order to establish tax exempt status with GF Health Products, Inc.

Please make a copy of the credit application for your records, and return the original credit application and resale certificate back via mail to the address stated above.

We require an opening order of \$300.00 before setting up the account. Catalogs and pricing can be sent to you by your sales representative once the account is set up.

Thank you for your interest in GF Health Products Inc.

New Accounts Department

P: 800-347-5678

F: 678-291-3174

GF Health Products, Inc.



GF Health Products, Inc.

Sales Rep Name: _____
 Date: _____

Customer's Legal Name: _____ DBA (If different) _____
 Mailing Address: _____ City _____ State _____ Zip code _____
 Shipping (If Different): _____ City _____ State _____ Zip code _____
 Phone: _____ Fax: _____ A/P Contact Person : _____ Email Address: _____

Are you a price group member YES NO If Yes, what group? (name one only) _____

Projected Purchases: Monthly \$ _____ Annually \$ _____ Amount of Credit Requested: _____

*For Credit Lines over \$25,000.00, a copy of financial statements should be attached to application.

Business Is A: Corporation Proprietorship Partnership
 Dealer Type: Medical-Surgical Dealer Home Health Care Dealer Rehab Long-Term Care Other _____
 Month/ Year Established _____ D & B No. _____ Federal Id No. _____ Accreditation No. _____

Principal Owners Name, addresses and Social Security No. of two corporate officers:
 1. _____
 2. _____

REFERENCES:

Name: _____ Account #: _____ Phone _____ Fax: _____
 Name: _____ Account#: _____ Phone: _____ Fax: _____
 Name: _____ Account#: _____ Phone: _____ Fax: _____

BANK REFERENCES:

Name of Bank: _____ Account#: _____ Address: _____
 Phone: _____ Fax: _____

This Authorizes the above references to release information regarding my accounts and loan experience with you to GF Health Products, Inc ("GF") or its Agents.

The undersigned hereby consent(s) to GF's use of a non-business consumer credit report on the undersigned in order to further evaluate the credit worthiness of the undersigned as principal(s), proprietor and/or guarantor(s) in connection with the extension of business credit as contemplated by this application. The undersigned hereby authorize(s) GF to utilize a consumer credit report on the undersigned from time to time in connection with the extension or continuation of the business credit represented by the credit application. The undersigned as (an) individual(s) hereby knowingly consent to the use of such credit report consistent with the Federal Fair Credit Reporting Act as contained in 15 U.S.C. @1681 et seq..The undersigned hereby guarantees the prompt and full payment of all indebtedness including all costs and attorney's fees necessary for collection and enforcement of this guaranty. The obligations of the undersigned shall be primary and not secondary and GF shall not be required to exhaust its remedies against Customer prior to enforcing its rights under this guaranty. The undersigned waives all rights of subrogation and set-off until all sums under this guaranty are fully paid. As consideration for GF's extension of credit to it, Customer grants GF a purchase-money security interest in and over all products sold to Customer by GF together with all proceeds derived directly from the disposal of such products. The undersigned hereby consents to the jurisdiction of the State of Georgia, County of Gwinnett, for resolution of all disputes and to the application of Georgia Law.

Signature: _____ Print Name: _____ Date: _____

UNIFORM SALES & USE TAX CERTIFICATE—MULTIJURISDICTION

The below-listed states have indicated that this form of certificate is acceptable, subject to the notes on pages 2-4. The issuer and the recipient have the responsibility of determining the proper use of this certificate under applicable laws in each state, as these may change from time to time.

Issued to Seller: GF HEALTH PRODUCTS, INC.

Address: 2935 NORTHEAST PKWY, ATLANTA GA 30360

I certify that:
 Name of Firm (Buyer): _____
 Address: _____

is engaged as a registered
 Wholesaler
 Retailer
 Manufacturer
 Seller (California)
 Lessor (see notes on pages 2-4)
 Other (Specify) _____

and is registered with the below listed states and cities within which your firm would deliver purchases to us and that any such purchases are for wholesale, resale, ingredients or components of a new product or service¹ to be resold, leased, or rented in the normal course of business. We are in the business of wholesaling, retailing, manufacturing, leasing (renting) the following:

Description of Business: _____

General description of tangible property or taxable services to be purchased from the seller: _____

State	State Registration, Seller's Permit, or ID Number of Purchaser	State	State Registration, Seller's Permit, or ID Number of Purchaser
AL ¹	_____	MO ¹⁶	_____
AR	_____	NE ¹⁷	_____
AZ ²	_____	NV	_____
CA ³	_____	NJ	_____
CO ⁴	_____	NM ^{4,18}	_____
CT ⁵	_____	NC ¹⁹	_____
DC ⁶	_____	ND	_____
FL ⁷	_____	OH ²⁰	_____
GA ⁸	_____	OK ²¹	_____
HI ^{4,9}	_____	PA ²²	_____
ID	_____	RI ²³	_____
IL ^{4,10}	_____	SC	_____
IA	_____	SD ²⁴	_____
KS	_____	TN	_____
KY ¹¹	_____	TX ²⁵	_____
ME ¹²	_____	UT	_____
MD ¹³	_____	VT	_____
MI ¹⁴	_____	WA ²⁶	_____
MN ¹⁵	_____	WI ²⁷	_____

I further certify that if any property or service so purchased tax free is used or consumed by the firm as to make it subject to a Sales or use Tax we will pay the tax due directly to the proper taxing authority when state law so provides or inform the seller for added tax billing. This certificate shall be a part of each order which we may hereafter give to you, unless otherwise specified, and shall be valid until canceled by us in writing or revoked by the city or state.

Under penalties of perjury, I swear or affirm that the information on this form is true and correct as to every material matter.

Authorized Signature: _____
 (Owner, Partner or Corporate Officer)

Title: _____

Date: _____