MASTERS®

Sales Rep: _____

Sales # _____

Call Center: YES NO

APPLICATION FOR CREDIT (CORPORATE)

A COPY OF LICENSES MUST BE FAX/EMAILED

FAX TO 800-201-6610 or EMAIL TO NewAccounts@MastersRx.com

Company Name (trade name if different) _____

Address (Billing) _____ City _____ State _____ Zip _____

Address (Ship To) _____ City _____ State _____ Zip _____

Phone: ( ) _____ - _____ Fax: ( ) _____ - _____ Email: _____

DEA License # _____ Exp. ____/____/____ State License # _____ Exp. ____/____/____

Type of Pharmacy: Retail LTC Specialty Center Other - _____ # of Locations ___
(Please check one)

CORPORATE OFFICERS AND/OR PARTNERS

1. Name _____ Title: _____ Phone: ( ) _____ - _____

2. Name _____ Title: _____ Phone: ( ) _____ - _____

Purchasing Agent: _____ A/P Contact _____

CREDIT REFERENCES

PRIMARY WHOLESALER _____

SECONDARY WHOLESALER _____

BANK NAME _____

Address _____ City_____ State ___ Zip _____ Phone: _____

We authorize you to check our company and personal credit rating and verify the information provided in this credit application. By signing, using, or requesting issuance of credit by Masters Drug Company, Inc. hereafter referred to as Masters, we agree to the following:

1. This is an unconditional corporate guarantee for credit extended by Masters or its subsidiaries in connection with the purchase of any and all goods. Further, the guarantor agrees to subject their company and themselves to the jurisdiction and venue of the Ohio courts.
2. We understand our terms are net 10 EOM subject to credit approval and agree to pay at the place designated on the invoice all drafts and obligations, evidence of credit, and all extensions of credit, and all finance charges when imposed, either:
   a. In full upon due date, or
   b. If not paid upon due date, a 1.5% monthly finance charge will be assessed
   c. On default or failure to pay as agree, you will pay to Masters or its subsidiaries collection costs, the maximum monthly finance charge permitted, and reasonable attorney's fees.
   d. Customer agrees to pay a 20% restocking fee on all AUTHORIZED returns. No Credit will be given to UNAUTHORIZED returns. By signing below I agree to the attached Return Goods Policy Terms and Conditions.
3. We hereby grant permission to Masters, its subsidiaries, affiliates, and agents to send advertising and promotional materials to the email(s) and fax number(s) listed above. This operates as consent under the 47 U.S.C. § 227 of the Telephone Consumer Protection Act.
4. We authorize Masters to register our company so we can order through **www.MastersRx.com**.
5 This agreement is binding on your heirs, representatives, successors, and assigns.

☐ *By checking this box, We agree to receive telemarketing calls from or on behalf of Masters Drug Company, Inc. or its agents or affiliates at the phone number provided above. We understand that consent is not a condition of purchase.*

_____ ____/____/____ _____ ____/____/____

Signature of Officer Date Signature of 2nd Officer *(optional)* Date

_____ _____

Printed Name Printed Name

_____ _____

Title Title