



# OxygenPlus

**Medical Systems Inc.**

2001 Woodhaven Dr.

Bedford, VA 24523

Phone: 1-540-586-9051 -- Fax: 1-540-586-9052

Email: [corporate@oxygenplusmedical.com](mailto:corporate@oxygenplusmedical.com)

## Credit Application

### General Information

Business Name: \_\_\_\_\_ Primary Contact Name: \_\_\_\_\_  
Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_  
Email Address: \_\_\_\_\_

### Billing Information

Billing Address: \_\_\_\_\_ Billing City: \_\_\_\_\_  
Billing State: \_\_\_\_\_ Billing Postal/Zip Code: \_\_\_\_\_  
Billing Country: \_\_\_\_\_

### Shipping Information

Check here if same as billing

Ship To Address: \_\_\_\_\_ Ship To City: \_\_\_\_\_  
Ship To State: \_\_\_\_\_ Ship To Postal/Zip Code: \_\_\_\_\_  
Ship To Country: \_\_\_\_\_

### Financial Information

Years in Business: \_\_\_\_\_ Company structure: Sole Owner Partnership  
Principals: \_\_\_\_\_ Corporation  
Accounts Payable Contact: \_\_\_\_\_ Accounts Payable Phone Number: \_\_\_\_\_  
Bank Reference: \_\_\_\_\_ Bank Phone Number: \_\_\_\_\_  
Bank Account #: \_\_\_\_\_

### Credit References

*Please provide three credit references*

Company Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
Company Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
Company Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

I verify that I am authorized to and hereby grant permission for \_\_\_\_\_ to release credit information to OxygenPlus Medical Systems Inc., 2001 Woodhaven Drive, Bedford, VA 24523

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Your Name: \_\_\_\_\_ Your Title: \_\_\_\_\_

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