

INTERNATIONAL DISTRIBUTOR APPLICATION

Kindly fill out the form below and submit to U.S. Orthotics. Your application will be forwarded to the president. customerservice@usorthotics.com

COMPANY NAME: PLEASE GIVE US A BRIEF OVERVIEW OF YOUR COMPANY

What is the name of your main contact?

Please provide your web site address.

Please list all of the geographic markets and/or countries into which you distribute products.

How can we reach you?

Telephone:

Fax:

E-mail:

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- What are your core areas of business?
 - Where is your corporate headquarters located? (city and country)
 - What U.S. Orthotics products are of interest to you?
 - What competitor products are in your area?
 - What is the registration process for importing medical products in your market?

- What regulations govern the import of medical devices in your country?

- What is the taxation rate on medical devices?

- Markets your company serves (check all that apply):
 - Hospitals
 - Surgery Centers
 - Nursing Homes
 - Home Health
 - Durable Medical Equipment
 - Physicians' Offices
 - Orthotics & Prosthetics
 - Retail
 - Other (specify)

Any other comments you would like are appreciated.



Customer Information Form

8605 Palm River Rd - Tampa, FL 33619 - 800-825-5228
www.usorthotics.com - Fax – 813-623-1055

COMPANY

Business Name _____ Phone _____

Street Address _____ Fax _____

Country & Region _____ Postal Code _____

Web Address _____ email address _____

Year Established _____

OWNERSHIP Type of Business Corporation _____ Partnership _____ Individual _____

President _____ Vice President _____

Treasurer _____ Accounts Payable Manager _____

FINANCE

Bank Name _____

Bank Address _____

City _____ State _____ Zip _____ Phone _____

TRADE REFERENCES Name Address City State Zip Phone Fax

1) _____ Fax _____

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2) _____ Fax _____

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3) _____ Fax _____

IMPORTANT: Our terms are net 30 days from invoice date. Any invoice past 60 days will result in a credit hold being placed on the account. A 1 ½% monthly service charge will be added on delinquent accounts starting from the date of invoice. I certify that the above information is true and correct and that I fully understand the credit terms and agree to proper payment in consideration of extended credit. All returns must be in original sealed packaging, have an authorization number and are subject to a minimum 20% restocking charge. Special orders are not returnable. If the business is a corporation, partnership or limited partnership the undersigned agrees to be personally responsible for any obligations of the company listed above. I authorize information pertaining to our credit and financial position to be released to U.S. Orthotics, Inc.
All financial information will be held in the strictest of confidence.

Date _____

Signed _____ Title _____

Signed _____ Title _____