CUSTOMER APPLICATION FORM

Suite #6, 9343 50 Street,
Edmonton, Alberta
T6B 2L5
Ph: 780.450.0204
Fx: 780.457.0054
Email: info@ajentismedical.com

Company Name: _____

Bill to Address: _____

Ship to Address if different than Bill to Address: _____

_____

Contact: _____

Direct Phone #: _____ **Cell #:** _____

Fax #: _____ **Email:** _____

Website: _____ **Prefer to Communicate Via:** _____

How did you hear about Ajentis Medical Inc.? _____

Main Interest: ☐ Monitor/ Defibrillation ☐ Medical Supplies ☐ Consulting ☐ Training

Previous Vendor Relationships: _____

Comments / Concerns: _____

_____

_____

Do you require contract pricing: ☐ Yes - please attach a list products
☐ No

After your product is received, how would you prefer us to follow up with you to ensure your satisfaction with your order? _____

PAYMENT INFORMATION

Preferred Method of Payment: _____

If Credit Card Provide #: _____ **Exp. Date:** _____

Card Holders Name: _____

Card Holders Signature: _____

Card Holders Address with Postal Code: _____

_____

Do you require a credit account? If so, please complete the attached Ajentis Credit Application Form.