

**CHRIST CENTERED MEDICAL SUPPLIES**  
**223 FM 1635**  
**Atlanta, TX 75551**  
**Phone: 1-888-635-5378**  
**Fax: 1-866-635-5379**  
**www.ccmedical.info**

APPLICATION FOR ACCOUNT

Date: \_\_\_\_\_

\*\*\*\*\*  
Agency Name: \_\_\_\_\_

Agency Address: \_\_\_\_\_

Agency Phone: \_\_\_\_\_ Agency Fax: \_\_\_\_\_

E-mail Address: \_\_\_\_\_ send invoices by email  yes  no

Web Site Domain Name: \_\_\_\_\_

Accounts Payable Contact Person: \_\_\_\_\_ Title: \_\_\_\_\_

\*\*\*\*\*  
Agency is:

government agency     proprietorship     partnership     corporation

tax exempt # \_\_\_\_\_, please attach a tax exempt certificate

if branch, please provide home office information below:

Contact Person: \_\_\_\_\_ Title: \_\_\_\_\_

Agency Phone: \_\_\_\_\_ Agency Fax: \_\_\_\_\_

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The above information will be used to service your account to the best of our ability. By signing you acknowledge that you have the authority to open an account for your agency. In addition, you understand that all invoices are due 30 days from receipt unless prior arrangements have been made.

Signature: \_\_\_\_\_ Title: \_\_\_\_\_

Print Name: \_\_\_\_\_ Date: \_\_\_\_\_