Nitto Avecia Pharma Services

Fax to:	**(949) 951-4909**
Attn:	

Customer Account Application

☐ **Open Account** ☐ **Credit Card**

COMPANY INFORMATION

LEGAL COMPANY NAME	**TAX ID #**
PARENT COMPANY	**DUNS #**
COMPANY ADDRESS	
MAIN TELEPHONE #	**FAX #**

BILLING INFORMATION

BILLING ADDRESS *(if different)*		
BILLING CONTACT	**BILLING PHONE**	
FAX #	**EMAIL ADDRESS**	**IS PURCHASE ORDER # REQUIRED ON ALL INVOICES?** ☐**YES** ☐**NO**

BUSINESS/FINANCIAL

TYPE OF OWNERSHIP

☐**CORPORATION** ☐ **PARTNERSHIP** ☐ **PROPRIETORSHIP** ☐ **NON-PROFIT** ☐ **GOVERNMENT AGENCY**

TYPE OF BUSINESS	**HOW LONG IN BUSINESS?** _____ **YEARS**	**ANNUAL SALES** $ _____

CREDIT INFORMATION

NAME	CONTACT PERSON	ACCOUNT NUMBER	PHONE & FAX NUMBER
BANK			
REFERENCE			
REFERENCE			
REFERENCE			

10 VANDERBILT, IRVINE, CA 92618 | TEL: 949.951.4425 | TOLL: 877.445.6554 | FAX: 949.951.4909 | WWW.AVECIAPHARMA.COM

AUTHORIZATION/CREDIT RELEASE	
The above trade name is adopted by the Undersigned, who is/are jointly responsible for all goods or services ordered in this name. Upon approval of credit, I/We agree to honor the Nitto Avecia Pharma Services (Avecia Pharma) credit terms of net 30 days in US Dollar funds. If payment is not made in accordance of terms, I/We understand that a service charge of 1 ½ % per month on past due accounts will accrue. **I/We authorize release ratings and payment record information as required to Avecia Pharma and understand that all information will be held in strict confidentiality.**	
AUTHORIZED SIGNATURE	**DATE**
PRINT NAME	**TITLE**
COMPANY NAME	**PHONE**
ADDRESS	

Nitto Avecia Pharma Services Use Only

SALES/CSR	**ACCOUNT #**	**APPROVED BY:**
DATE SUBMITTED:	**CL:**	**ENTERED BY:**

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