CREDIT APPLICATION

COMPANY NAME: _____

Street_____City_____Province_____

Postal Code _____Telephone No._____Fax No. _____

SHIPPING ADDRESS: (If different from Billing Address Above): _____

Street _____City_____Province_____

Postal Code _____ Telephone No._____ Fax No._____

TRADE REFERENCES (Other Fine Chemical Suppliers):

Name:	**Address:**	**Telephone #:**	**Fax#:**

1. _____

2. _____

3. _____

FINANCIAL INSTITUTION DETAILS

Name of Institution_____

Street_____City_____Province_____

Account Number _____

Contact Name: _____

Fax Number: _____

Telephone: _____

REQUIRED CREDIT LIMIT _____

The following statement requires the applicants signature:
I hereby consent to routine credit verification by Almat Pharmachem Inc.

_____ _____
Authorized Signature Date

TERMS: NET 30 DAYS, unless otherwise specified in writing.
A monthly service charge of 1.5% will be applied on all overdue amounts.

RETURN COMPLETED FORM TO: **ALMAT PHARMACHEM INC**.
Attention: Customer Service
57 Corstate Ave. Suite 200
Concord, Ontario, L4K 4Y2
Fax Number: 905-761-8440

Sales Rep: _____