imprimis Rx

Pharmacy Creations, LLC

A Wholly Owned Subsidiary of Imprimis Pharmaceuticals, Inc.

CREDIT APPLICATION AGREEMENT

Please fill out the form below if you would like to request to be invoiced.
Please type or clearly print. Once complete please e-mail (CLIENTSERVICES@IMPRIMISPHARMA.COM) or fax (858-436-7294) this form to Client Services along with all other new customer forms.
If you have any questions regarding this application, please call 858-704-4644.

Facility Name:		FEIN:	
Phone:		Fax:	
Contact:			
Contact E-mail Address:			
Facility Address:			
City:		State:	ZIP Code:
Corporation ☐	Sole proprietorship ☐	Partnership ☐	Other:
Corporation Name:			
Corporate President:		Corporate Secretary:	
Partner's Name:		Partner's Name:	
Date business commenced:			
How long under Present Ownership?			

BUSINESS/TRADE REFERENCES

Company name:			
Address:			
City:		State:	ZIP Code:
Phone:	Fax:	E-mail:	
Type of account:			
Company name:			
Address:			
City:		State:	ZIP Code:
Phone:	Fax:	E-mail:	
Type of account:			
Company name:			
Address:			
City:		State:	ZIP Code:
Phone:	Fax:	E-mail:	
Type of account:			
Name of Bank:			
Account No:		Account Type:	
Address:			
City:		State:	ZIP Code:
Phone:	Fax:	E-mail:	
Bank Officer:			

AGREEMENT
1. All invoices are to be paid 30 days from the date of the invoice. 2. All delinquent accounts are subject to a late fee of 1 ½% per month. 3. Claims arising from invoices must be made within seven working days. 4. By submitting this application, you authorize Pharmacy Creations, Inc. to make inquiries into the banking and business/trade references that you have supplied. Your signature certifies the above information is true and correct, and reflects that you are authorized to bind your company.

SIGNATURES	
Title: Date:	Title: Date:

For Office Use Only:	CM Approval:	Date: