



*making your practice perfect*

**F2 Medical Supplies Limited**  
**11 Midland Street – The Cultural Quarter**  
**Leicestershire**  
**LE1 1TG**  
**Telephone: 0116 319 1182**  
**Email: [accounts@f2medicalsupplies.com](mailto:accounts@f2medicalsupplies.com)**

## Credit Account Application Form

### BUSINESS CONTACT INFORMATION

|  |  |  |  |
|--|--|--|--|
| Company Registration Number / Reference: |  | Trade Contact Persons Name*                  |  |
| Company name*                            |  | <input type="checkbox"/> Sole proprietorship | <b>Delivery Address:</b><br>(If different to registered company address) |
| Main Telephone Number*                   |  | <input type="checkbox"/> Partnership         |  |
| Main E-mail Address*                     |  | <input type="checkbox"/> Corporation         |  |
| Registered company address*              |  | <input type="checkbox"/> Other               |  |

### ACCOUNTS AND CREDIT INFORMATION

|                             |               |                    |  |
|-----------------------------|---------------|--------------------|--|
| Main Contact Person*        |               |                    |  |
| Accounts Telephone Contact* |               |                    |  |
| Extension (If Applicable)   |               |                    |  |
| Fax                         |               | Account Reference: | <b>To be confirmed by F2 Medical Supplies Ltd.</b> |
| Accounts E-mail*            |               |                    |  |
| Type of account             | <b>Credit</b> | Ref:               | <b>Supply Of Goods</b>                             |

### AGREEMENT

1. All invoices are to be paid 30 days from the date of the invoice unless confirmed otherwise with an account manager and authorized by F2.
2. Claims arising from invoices must be made within seven working days from the invoice date. Additional information can be found on your invoice copy.
3. By submitting this application, you agree to the Terms and Conditions as provided by F2 Medical Supplies Ltd and authorize F2 Medical Supplies Ltd to make a soft credit inquiry via our credit recommendation provider to provide a suitable credit limit and terms.

I CONFIRM I HAVE READ THE ABOVE AND AM IN AN AUTHORISED POSITION TO REQUEST A CREDIT ACCOUNT TO BE CREATED ON BEHALF OF THE ABOVE DETAILED COMPANY, FOR THE SUPPLY OF GOODS FROM F2 MEDICAL SUPPLIES LTD:

|                   |  |            |  |
|-------------------|--|------------|--|
| Name*             |  | Signature* |  |
| Title / Position* |  |            |  |
| Date*             |  |            |  |