



Please return this form by fax to:  
**(949) 587-8436**

Attention:  
**Finance Dept.**

**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 <i>(if different)</i>		
BILLING CONTACT	BILLING PHONE	
FAX #	EMAIL ADDRESS	IS A PURCHASE ORDER # REQUIRED ON ALL INVOICES? <input type="checkbox"/> YES <input type="checkbox"/> NO

**BUSINESS/FINANCIAL**

TYPE OF OWNERSHIP		
<input type="checkbox"/> CORPORATION <input type="checkbox"/> PARTNERSHIP <input type="checkbox"/> PROPRIETORSHIP <input type="checkbox"/> NON-PROFIT <input type="checkbox"/> GOVERNMENT AGENCY		
TYPE OF BUSINESS	YEARS IN BUSINESS	ANNUAL SALES
_____	_____ YRS	\$ _____

**CREDIT INFORMATION**

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



**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 Irvine Pharmaceutical Services, Inc. (IRVINE) credit terms of net 30 days in US Dollar funds (unless an alternative payment term has been mutually agreed upon/signed). If payment is not made in accordance of terms, I/We understand that a service charge of 1.5% per month on past due accounts will accrue.

I/We authorize release ratings and payment record information as required to IRVINE and understand that all information will be held in strict confidentiality.

AUTHORIZED SIGNATURE	DATE
PRINT NAME	TITLE
COMPANY NAME	PHONE
ADDRESS	

*Irvine Pharmaceutical Services, Inc. – For Internal Purposes Only*

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