

INTERSTATE **Account Set Up Form/Credit Application**

LAB GROUP

Please complete the following information. Please write legibly.

1. Set up Account at: ☐ Interstate Lab Group-Mansfield ☐ Interstate Lab Group-Indiana

2. Fill in exactly how you want the account name and address to appear:

Circle One

Name: _____ O.D. M.D. Optician Other

(To avoid potential confusion, this name should reflect how your office will identify yourself when calling us.)

Name 2: _____

(If you have a secondary company name or Doctor name)

Ship-to Address: _____

City: _____ State: _____ Zip: _____

Bill-to Address (If different from ship to address): _____

City: _____ State: _____ Zip: _____

Preferred Payment Method: _____ Expected Monthly Volume \$ _____

Tax exempt ☐ Yes ☐ No

If yes, please include a copy of your states exemption form with your application.

Send me notifications: ☐ Yes ☐ No

Notification method: ☐ Fax ☐ Email

Please select the information you would like to be notified about.

☐ Delays ☐ WIP ☐ Statements (email only)

3. Phone Number: _____

Fax Number: _____

4. Main Contact Person for Questions: _____ E-Mail Address: _____

5. Day(s) office is closed: _____

6. Preferred shipping method _____ Courier _____ UPS

7. Direct Bill/Buying Group Options:

Direct Bill

Bill through buying group

Group name: _____

7a. Buying group Number, if applicable: _____

8. Dr. Alliance (if applicable): _____

9. How did you hear about us (if applicable): _____

10. Additional Comments / Special Instructions: (including other accounts you have with us) _____

Thank you for your interest in us! Upon completion of both pages please email to Cbrandt@interstatelabgroup.com or fax to attn: Chloe Brandt at 419-529-6801

Interstate Lab Group- Ohio
680 Lindaire Lane
Ontario, OH 44906
Toll Free Ph: 1.800.472.5790 Toll
Free Fax: 1.800.342.4136

INTERSTATE
LAB GROUP

Interstate Lab Group- Indiana
2902 Mitthoeffer Place
Indianapolis, IN 46229
Toll Free Ph: 1.800.564.5546
Toll Free Fax: 1.800.506.4704

Please complete all areas to avoid delay of your credit review and your order.

Tax ID (FEIN): _____

☐ CORPORATION

☐ PARTNERSHIP

☐ SOLE PROPRIETORSHIP

☐ NON-PROFIT

Legal Company Name: _____ Date Business began:

Doing business as: _____ DUNS # (if applicable): _____

Location of business (no P.O.s please): _____

City: _____ State: _____ ZIP: _____

Phone: _____ FAX: _____

Billing address: _____ Attn: _____

(if different) Address: _____

City: _____ State: _____ ZIP: _____

☐ Check if this is the sole location of business.
If not, please list other locations of this business,
or affiliated companies:

Owner(s) of business, home address & phone number:

Bank: _____ Acct. #: _____

Bank contact: _____ Bank contact phone: _____

Credit References:

For example Current wholesale lab supplier

Name: _____ Acct. #: _____
Address: _____
City: _____ State: _____ ZIP: _____
Phone: _____ Contact: _____ High Credit: \$ _____

Name: _____ Acct. #: _____
Address: _____
City: _____ State: _____ ZIP: _____
Phone: _____ Contact: _____ High Credit: \$ _____

Name: _____ Acct. #: _____
Address: _____
City: _____ State: _____ ZIP: _____
Phone: _____ Contact: _____ High Credit: \$ _____

In consideration of granting and extending credit by The Interstate Group of laboratories to the undersigned, the undersigned does hereby agree to promptly pay all sums when due. In the event of non payment, the undersigned does hereby understand and agree to pay the sum of 2.0% late payment fee per month on the total statement amount, beginning with the 1st day following statement date and thereafter until the account is paid in full.

Also, the undersigned does hereby understand and agree to pay all collection costs, attorney fees and court costs up to 50% of the outstanding balance if collection procedures are warranted. Further, the undersigned submits to the jurisdiction of the courts of the State of Ohio for the adjudication of any dispute concerning this agreement and for the collection of all amounts owed by the undersigned, and agrees that the venue of any such action shall be in Mansfield, Richland County, Ohio. The parties mutually waive the rights either may have to demand a trial by jury of any dispute arising between them.

The undersigned has read, understands and personally guarantees agreement to the terms stated above. I certify that the information provided is true and correct.

Signature: _____ Date: _____

Print name: _____