New Client Information Application

Business Contact Information

Company Name _____

Phone _____ Email _____

Address _____

Billing Information

Bank Name _____

Bank Address _____

Routing Number _____ Account Number _____

Agreement

1. All invoices are to be paid within 30 days from the date of the invoice. Invoices not paid within this time period are subject to late fees.
2. Claims arising from invoices must be made within 7 business days.
3. By submitting this application, you are authorizing Summit Nutritional Laboratories to make inquiries to the billing information you have provided.

Signature

_____ _____

Signed Date

Credit Card Authorization Form

PLEASE COMPLETE FORM IN ITS ENTIRETY AND FAX TO 801.798.7944
ALONG WITH A COPY OF THE CREDIT CARD (FRONT AND BACK)

Billing Information

Company Name_____

Credit Card Billing Address_____

City/State/Province_____ Zip Code/Postal Code_____

Phone Number_____

Credit Card Information

Card type:

◯ American Express ◯ Visa ◯ Mastercard ◯ Other (Please specify):

Name As Shown On Card _____

Credit Card #_____ CCV # _____

Expiration date _____

Authorization

Total Charge Amount $_____ USD Funds CDN Funds

Transaction Reference: Invoice Sales Order #_____

I hereby authorize Summit Nutritional Laboratories to charge the above amount and I agree to pay this amount according to card issuer agreement.

_____ _____

Signed Date