Medtronic

Please complete the form, sign and return to "rs.cancustomermaster@medtronic.com"

CUSTOMER PROFILE

Legal Name:		
City:	**Province:**	**Postal Code:**
Telephone #:	**Fax #:**	
Website:	**Email Address:**	
Bill To Address:		
Ship To Address:		
Accounts Payable:	**Tel #/Ext:**	
Email Address:		

Print Name:	**Title:**
Signature:	**Date:**

PAYMENT TERMS

Credit Card (Pay upon order) ☐	**Net 30 Terms** ☐

***** If you will pay by Credit Card, please fill in the Customer Profile section only and check Credit Card Payment Terms in the above.**

TERMS OF SALE: NET 30 DAYS FROM DATE OF INVOICE

Failure to adhere to our terms may result in a shipping hold on future orders. The net due date is calculated from the date of the invoice. I hereby certify that the information set forth here, together with all other information submitted in connection with this application is true and correct. I agree to pay all costs of collection, including actual out-of-pocket expenses and a collection fee of 25% if collected through a collection agency or attorney. I/we hereby take notice that Medtronic of Canada Ltd will rely on this information in extending credit to me/us. I/we hereby notice that Medtronic of Canada will be using the attached and signed credit application to obtain bank reference information, including account balances and other credit information and may be referring to a consumer/commercial credit report respecting us/me containing personal information and/or credit information. In connection with my/our application for credit, I/we hereby take notice that Medtronic of Canada Ltd will have access to this application, which may contain personal and identifying information as defined in Canadian Privacy Legislation. I/we have read and understood the Terms of Sale and agree that such terms apply to all transactions with Medtronic of Canada Ltd.

COMPANY INFORMATION

Type of Organization:	**Corporation** ☐		**Partnership** ☐	**Proprietorship** ☐
Years in Business:			**Type of Business:**	
Annual Sales:		**Will the product be resold or distributed:**		
Credit Amount Requested:			**Products Interested in Purchasing:**	
Estimated Initial Order:			**Expected Annual Purchase:**	
Taxable:	**Yes** ☐	**No** ☐		
If GST non-taxable, provide Tax Exempt Certificate #:				
If PST non-taxable, provide Tax Exempt Certificate #:				

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BANK REFERENCE

Bank Name:		
Address:		
Account Manager:	**Tel #:**	**Fax#:**
Account No.:	**Email Address:**	

TRADE REFERENCES

Company Name:		**Account No.:**
Address:		**Tel #:**
Contact Name:	**Email Address:**	

Company Name:		**Account No.:**
Address:		**Tel #:**
Contact Name:	**Email Address:**	

CUSTOMER SEGMENTATION

Primary (Choose one)	☐ HOSPITAL	☐ ALTERNATE SITE	☐ CONTINUING CARE	
Secondary (Choose one within primary selected)	☐ Public Hospital	☐ Blood Service/ Private Lab ☐ Dentist Office ☐ Pharmacy ☐ Veterinary Office	☐ Diagnostic Imaging Center ☐ Emergency Medical ☐ Extended Care Facility ☐ Government ☐ Health Miscellaneous ☐ Home Health Care Provider ☐ Public Clinic	☐ Physician Office / Clinic ☐ Respiratory Services ☐ School ☐ Sleep Clinic Surgical Center ☐ Transitional Care (Rehab) ☐ University Hospital/Medical Center

Sales Rep Name:	**Date:**