Biocomposites®

New Hospital Account Form

Please complete this form and email to usorders@biocomposites.com

****THIS FORM MUST BE COMPLETED BY A SALES REPRESENTATIVE****

Hospital Information:

Hospital Name:	
Hospital Main Address:	
City / State / Zip:	

Inventory Type:	☐ Official Consignment – Requires Contract ☐ Stock ☐ Rep Delivery

Distributorship:		Rep/Team Name:	
Distributor Type:		Rep Phone:	
Distributor Phone:		Rep Email:	
If Applicable, FMS:		FMS Patch Account:	☐ Yes ☐ No

Hospital Purchasing & Account Information:

Biocomposites Payment Terms:	***Net 30 days***	Hospital Payment Terms:	Net _____ days	Approved: ☐ Yes ☐ No
A/P Contact:		Phone:		
Email Address:				

Purchasing Agent:		Phone:	
Email Address:			

Hospital Type:	☐Non-Profit	☐ For Profit	☐ Government
Tax ID:		**Tax exempt?** **If yes, please attach certificate*	☐ Yes ☐ No

Product Pricing:

STIMULAN Rapid Cure 3cc **620-003**	$	STIMULAN Kit 5cc **600-005**	$
STIMULAN Rapid Cure 5cc **620-005**	$	STIMULAN Kit 10cc **600-010**	$
STIMULAN Rapid Cure 10cc **620-010**	$	genex Bone Graft Substitute 5cc **910-005**	$
STIMULAN Rapid Cure 20cc **620-020**	$	genex Bone Graft Substitute 10cc **910-010**	$
STIMULAN Bullet Mat & Introducer **660-001**	$	OsteoPrecision™ Graft Delivery Device **990-001**	$

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