"Your Outsourcing Partner"

CREDIT APPLICAITION

Laboratory Name_____Phone_____
Name of owner_____Fax_____
Laboratory Address_____

Name of Bank_____
Bank Address_____
_____
Bank Phone #_____Fax_____
Bank Contact

Credit Card Number_____Expiry Date_____
Name of cardholder as it appears on card_____
Billing Address_____
_____

_____Province_____Postal Code_____

Applicant's Signature_____

Your payments will be processed automatic on the 2nd day of the month for the statement owned the prior month. We accept Visa and MasterCard only. By giving your credit card number the cardholder agrees to be personably liable for all debt incurred at UniNature Dental Enterprise, even if the laboratory is incorporated.

You may request to make payment by check. We will need to receive your check by the 20th of the month, please call accounting to set up your request. If full payment is not received then your requests will be put on hold until the amount owed is paid in full.

UniNature runs a credit check for anyone paying by check. By signing below you are giving permission for UniNature to run a credit check.

I hereby certify the information provided in this application is true, correct, and complete as of the date indicated below. I agree to promptly notify UniNature Dental Enterprise of any changes in the information provided.

Customer's signature_____Date_____