Credit Application

Credit terms of 30 days may be established upon approval by completing this application. Any charges incurred during the application process will be passed on to the applicant. Credit Cards are accepted in the interim.
Please type or print all information and mail or fax completed form to:
Alcrea Health, 600 Boyce Road, Pittsburgh, PA 15205 U.S.A. FAX: (412) 722-0535 Attn: Credit Department

Name _____ Phone ( )_____ Fax ( )_____

Address _____

Type of Business _____ Year Business Established _____

Email Address _____

Ownership (check one) ❑ P.A. ❑ Sole Proprietor ❑ Partnership ❑ Corporation

Principals

_____ Title _____

_____ Title _____

_____ Title _____

Contact for further company information _____ Phone ( )_____

References

1) Business _____

_____

_____

Phone ( ) _____ Fax ( ) _____

Account # _____

2) Business _____

_____

_____

Phone ( ) _____ Fax ( ) _____

Account # _____

3) Business _____

_____

_____

Phone ( ) _____ Fax ( ) _____

Account # _____

4) Bank _____

_____

_____

Account Manager _____

Phone ( ) _____ Fax ( ) _____

Checking Accounts _____

Loan Accounts _____

Additional Comments _____

_____

_____

The above representations have been made to Alcrea Health for the purposes of obtaining credit and to the best of my knowledge are accurate in all respects. I authorize you to verify the credit information with my bank(s) and business references.

Signed by _____ Date _____

Title _____

Office Use _____

1-866-425-2732
alcrea-health.com

ALCREA HEALTH