PROLAB
ORTHOTICS
Evidence-Based Medicine

NEW CLIENT APPLICATION

Fax: 707.257.4420 or Email: cs@prolab-usa.com

CLIENT INFORMATION

Practice name ______________________________

Practitioner ______________________________ Discipline ____________

Affiliated practitioners who will use this account ______________________________

Shipping address ______________________________

City ____________________ State ____________ Zip __________ Country ____________

Phone ______________________________ Fax ____________________

Practitioner's Email ______________________________

Your email address is protected and used solely by ProLab

BILLING ADDRESS (if different from above)

Billing address ______________________________

Attention ______________________________

City ____________________ State ____________ Zip __________ Country ____________

Phone ______________________________ Fax ____________________

Billing Dept. Email ______________________________

BILLING INFORMATION

Do you require ProLab to list *Medical Record Numbers* on each order? Yes No

Will you provide a unique *Purchase Order Number* for each order? Yes No

Other special instructions______________________________

OTHER INFORMATION

Type of Business ☐ Sole Proprietorship ☐ Partnership ☐ Corporation

Year Established ____________

Officers or Partners ______________________________

Tax Exempt ☐ No ☐Yes (*If yes, California practitioners must attach a copy of resale certificate)*

CREDIT AGREEMENT

Terms of this account are net thirty (30) days from the date of the invoice. A service charge of 1.5% will be added to all past-due amounts (18% annum). Discounts will not be given on past-due accounts.

Complete the Credit Card Authorization Form to pay by credit card

Signature of Officer/Owner or Partner ______________________________

Print Name and Title ______________________________ Date ____________

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