



BIO-TISSUE

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Please complete and
fax to: (305) 412-4429

For office use only

Customer Code: _____

Rep Code: _____

C.T.: _____

C.C.C.: _____

Assigner: _____

FACILITY INFORMATION:

Facility/Hospital Name: _____

Purchasing Contact Name: _____

Phone: _____ Fax: _____ E-mail: _____

Facility Type: Hospital Surgery Center Private Practice Other: _____

BILLING INFORMATION:

Billing (Accounts Payable) Contact Name: _____

Billing Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____ E-mail: _____

Federal Tax ID (FEI): _____

SHIPPING INFORMATION:

Shipping Facility Name: _____ Shipping Contact Name: _____

Phone: _____ Fax: _____ E-mail: _____

Shipping Address: _____

City: _____ State: _____ Zip: _____

PAYMENT INFORMATION:

American Express / Visa / Mastercard ONLY

Credit Card Number: _____ Expiration Date: _____ V Code: _____

Card Holder's Name: _____

Billing Address: _____

City: _____ State: _____ Zip: _____ Country: _____

Phone: _____ Ext: _____

Card Holder's Signature: _____ Date: _____

As the credit card holder, I authorize Bio-Tissue, Inc. to charge my credit card for future purchases verbally (or written) when approved by me.

Your completion of this account application form helps us protect you, our valued customer, from credit card fraud. Bio-Tissue, Inc. will keep all information entered on this form strictly confidential.

REFERENCES: (Company name, contact name, address, phone, fax, and account number):

1. _____
2. _____
3. _____

