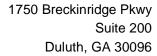


1750 Breckinridge Pkwy Suite 200 Duluth, GA 30096

Credit Application

General Information:	
Business Name	Credit Terms Requested Net 15 Net 30
DBA	Credit Limit Requested \$
Address	Buiness Website
	Business Phone
	Buiness Fax
Billing Address	Tax ID (or SS#)
	A/P Contact
#Yrs in Bus.	Phone/Email:
Corporation Partnership Sole Propie	etor S-Corporation LLC or LLP Other
Names of Owners, Partners, or Officers:	
Bank Reference:	
Bank Name	Branch
Address	Phone
	Fax
Loan Officer	Credit Line
Checking Acct	Loan Acct No
T . D .	
Trade References:	
Name	Name
Address	Address
Phone	Phone
Fax	Fax
Account No	Account No
Purchase Orders: Fax to 678-680-5818 or Email to cust	tomerservice@protherapysupplies.com
Authorization:	
Pro Therapy Supplies is hereby authorized to obtain any information	necessary to establish credit worthiness from any source listed
on this credit application and we release any souce from all liability for	
solely for the purpose of establishing credit for purchasing products	from Pro Therapy Supplies.
Printed Name of Applicant	Title
Signature	Date





Pro Therapy Supplies, LLC Credit Card on File Authorization Form

l,			hereby authorize	PTS to keep my cred	dit card number on file	e and to use	
that number to pay any	fees associate	ed with my proc	duct orders.				
his is to verify that I,				authorize PTS to pay my account with the use of my			
MasterCard, Visa, Disco	over or Americ	an Express cre	edit card.				
By this credit card docu	ment I hereby	give my compl	lete approval to pay in fo	ull for all specific prod	lucts and/or services	which I have	
directly ordered and aut	horized to be p	ourchased from	n PTS. PTS will only cha	arge my card, for ord	ers placed upon my a	authorization.	
I understand that the ch	arge reflected	on my credit c	ard statement will be in	the name of Pro The	rapy Supplies LLC ar	nd/or PTS. My	
authorized signature on	this form will b	oe valid for "AN	NY FUTURE, ON-GOIN	G, PRODUCT PURC	HASES INCLUDING	BUT NOT LIMITE	
TO ADDITIONAL BILLI	NG."						
Today's Date:		Nam	ne (as printed on card):				
Company Name:							
Address:			State/Zip:				
Address: City:			State/Zip:				
Address: City: Phone Number:			State/Zip: Fax Numbe				
Company Name: Address: City: Phone Number: Bank Name (on card): Type of Credit Card:			State/Zip: Fax Numbe				
Address: City: Phone Number: Bank Name (on card): Type of Credit Card:	Amex	Visa	State/Zip: Fax Numbe	r:MasterCard	/		
Address: City: Phone Number: Bank Name (on card): Type of Credit Card: Credit Card #:	Amex /	Visa	State/Zip: Fax NumbeDiscover	r:MasterCard Exp date:		— ht side of card):	
Address: City: Phone Number: Bank Name (on card): Type of Credit Card: Credit Card #: CVC Code:	Amex/(Ame	Visa / ex is 4 numbers	State/Zip: Fax Numbe Discover / s on front right side of c	r:MasterCard Exp date: ard, Other cards is 3		ht side of card):	
Address: City: Phone Number: Bank Name (on card): Type of Credit Card: Credit Card #:	Amex / (Ame	Visa / ex is 4 numbers	State/Zip: Fax NumbeDiscover / s on front right side of c	r:MasterCard Exp date: ard, Other cards is 3	numbers on back rigl	ht side of card):	

By signing above, I acknowledge the above authorization and treat this fax as a copy of my signature on file. I agree to abide by the terms and conditions set forth by PTS policy statement and the issuing credit card company. Furthermore, I understand and agree that the charges specified above are irrevocable and may not be charged back at any time in the future and that all sales are final.

To complete this authorization, please fax a photocopy of the card holder's valid driver license or official picture identification (passport, military id, etc) and the front and back of the signed credit card (please enlarge and lighten copies to make viewable over fax). Print and fax the completed form and the photocopies described to 678-680-5818 or mail completed form and photocopies to Pro Therapy Supplies, 1750 Breckinridge Pkwy, Suite 200, Duluth, GA 30096. Photocopies and signature **are required to process** your order. This is for your protection as well as ours. All transactions are subject to approval. Your order cannot be processed until this signed document is on file. This credit card policy aims to protect you, our valued customer, from any fraudulent use of your card by persons other than an authorized card holder. This process helps us ensure that all our customers are fully informed and protected. If you no longer desire your credit card information to be retained on file, please call us and we will immediately destroy this form. We may also, at our discretion, review all such forms on file and destroy those that have not been used for an extended period of time. Should we deem this necessary, you may be required to submit a new authorization form in the future. We thank you very much for your cooperation and good will.