ACCOUNT APPLICATION

Dan Kovacic R.T.O. (c)

Kovacic Orthopedic Tool & Supply Corp.

269 Walker St., Unit # 515, Detroit MI, 48207, USA
3910 Acorn Cres., Windsor ON, N8W 5R4, Canada

Phone: 1-800-665-1176 **Fax:** (+1) 519-997-6894 **Email:** info@kovacicorthopedic.com

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Legal Name of Firm: _____
Name of Parent Co. or Subsidiary: _____
Street Address : _____ **City :**_____**State :**_____**Zip Code :** _____

Phone : _____ **Fax :** _____ **Email:** _____
Years in Business : _____ **No. of Employees :** ___ **Fed. Tax ID # :** _____**Tax Exemption # :** _____
Ownership Type : 1.) Corp☐ **2.) Ltd.**☐ **3.) Partnership**☐ **4.) Government** ☐ **5.) Other:**_____

Estimated Credit Required : $ _____

Payment Terms : Net 30 Days (interest of 1.5% monthly 18% Annually)

Billing Address : ☐ **(Same as Above)**

Street : _____ **City :**_____**State :**_____ **Zip Code :** _____

Shipping Address : ☐ **(Same as Billing)**

Street : _____**City :**_____**State :**_____ **Zip Code :** _____

Officer Information:

Name : _____ **Title :** _____
Street Address : _____ **City :**_____**State :**_____ **Zip Code :** _____
Phone : _____ **Fax:**_____

Names of Authorized Purchasing Agents:

1. _____ /_____ 2. _____ /_____

3. _____ /_____ 4. _____ /_____

Please Print Please Sign Please Print Please Sign

Officer : _____ Title : _____ Date : _____
The undersigned gives purchasing authority to the agents listed above. (month / day / year)

References : (minimum 6 month history)

Co. Name : _____ **Contact :** _____ **Phone :** _____
Co. Name : _____ **Contact :** _____ **Phone :** _____
Co. Name : _____ **Contact :** _____ **Phone :** _____

Bank Name : _____ Contact : _____ Phone : _____
Street Address : _____ City :_____State:_____ Zip Code : _____
Account # _____

Applicants Signature / Title : _____ / _____ Print Name : _____
Date : _____
(month / day / year)

The Contact Above Gives Authorization for Kovacic Orthopedic Tool & Supply Corp. To Contact All

References Listed Above In Regards Of A Credit Account Approval

TERMS & CONDITIONS

The Buyer Agrees with seller Kovacic Orthopedic Tool & Supply Corp. to pay for purchase(s) within 30 days of invoice date, otherwise a 1.5% interest will accumulate monthly to a yearly maximum of 18%. Unpaid purchases after 30 days may require pre-payment of future orders.

Currently Sales Tax only applies to purchases made within Michigan, unless provided with a Tax Exemption Certificate and all funds are in US dollars.
Out of State purchasers assume payments in their State for any Use Tax, if they Use or Consume Property Purchases as subjected by State Law.

Warranty Disclaimer

Kovacic Orthopedic Tool & Supply Corp. warrants its products to the original purchaser(s) thereof to be free of defects in materials and workmanship for a period of 1 to 10 years depending on the product purchased, Not including Direct or Indirect Damage caused by Accident, Abuse, Alteration, Misuse, Repair, Neglect, Normal Wear, or Lack of Maintenance.

Liability Disclaimer

In No event under any circumstance will Kovacic Orthopedic Tool & Supply Corp., Nor its Service Providers, and any other Party involved in the Creation and Supply of Any Product(s) be held liable to any Party for any Damages of any kind; Direct, Indirect, Incidental, Special, Punitive, or Consequential Damages, Business Interruptions, or Revenue Due to Use and Non Use of any Product(s)

Certain Aspects of the Disclaimers above May or May Not Apply to you, and You May have Other Rights.

Returns

For Returns please Contact us at info@Kovacicrthopedic.com or Call 1-800-665-1176 Providing **Proof of Purchase and Reason for Return**. Once approved a R.A. # will be issued to Confirm Return and Sender will be Responsible for Shipping, unless it is our error. i.e. (wrong shipment, manufacturing defect, under warranty)

Returns & Payments: Kovacic Orthopedic Tool & Supply Corp. **269 Walker St. Unit # 515, Detroit MI, 48207, USA**

Changes

The Information contained Above may Change from time to time, If you have any Questions
Please Contact us at: **Email :** info@kovacicorthopedic.com **Toll Free:** 1-800-665-1176

The Applicant has read understands and agrees All Information is True & Correct, and will Notify us in writing within 21 Days of any Change.

Name : _____ **Title :** _____ **Signature :** _____
Date : _____
(month / day / year)