

Date: _____

Salesperson: _____

Name of Business: _____

Name of Owner(s) : _____

Address: Bill to: _____ Ship to: _____

Phone #: () _____ - _____

Fax #: () _____ - _____

E-mail address: _____

Business Type: Sole Proprietorship Corporation Partnership

Sales Tax Status: Charge Tax Resale Tax Exempt

Federal Tax ID #: _____ (please attach license / certificate)

X-Ray Film Volume \$ _____ (per month estimate)

UMG Dealership Statement

Dealership agrees that all UMG / Fuji medical products will not be sold or provided to any hospital.

Non-compliance of this written statement / condition may result in termination of the UMG dealer agreement. UMG reserves the right to terminate any and all assigned UMG dealerships at its own discretion.

Please sign below to acknowledge that you have read and understand the above statements / conditions.

Name of Dealership: _____

Name of Signer: _____

Authorized Signature: _____ Date: _____

					Salesperson			Date		
Business	Legal Business Name									
	Street Address						Fax			
	City - State - Zip						Telephone Number			
	Circle One Sole Prop. Partnership Corporation				Presentl U.M.G. Customer Yes No		D & B Rating			
	Year Established	Estimated Monthly Purchases		Parent Company Affiliation			No. of Employees			
Owner, or Chief Officers	Name				Name					
	Title			Social Security No.		Title		Social Security No.		
	Home Street Address			Fax Number		Home Street Address		Fax Number		
	City - State - Zip			Telephone Number		City - State - Zip		Telephone Number		
Business References				Office Use Only - Do Not Complete						
Name		Account #		How Long Sold	Last Sale Date	Recent High Credit	Now Owe	Amt. Past Due	Terms of Sale	Payment Record
							\$	\$		
Street Address				Comments						
City - State - Zip		Phone #								
Individual to Contact		Fax Number								
Name		Account #		How Long Sold	Last Sale Date	Recent High Credit	Now Owe	Amt. Past Due	Terms of Sale	Payment Record
							\$	\$		
Street Address				Comments						
City - State - Zip		Phone #								
Individual to Contact		Fax Number								
Name		Account #		How Long Sold	Last Sale Date	Recent High Credit	Now Owe	Amt. Past Due	Terms of Sale	Payment Record
							\$	\$		
Street Address				Comments						
City - State - Zip		Phone #								
Individual to Contact		Fax Number								
Bank Reference				Checking Account			Loan Experience			
Name				Cust Since	Avg. Balance	N.S.F. Checks Yes No		Date	Amount	Payment Record
Street Address		Phone #		Comments						
City - State - Zip		Fax Number								
Loan Officer		Checking Account Number								

Please fax completed application to: (914) 835-6111