



**SURGICAL SERVICE
CUSTOMER APPLICATION FOR
CREDIT**

SS District # _____ **Agiliti Account #** _____

Application must be completed in full and returned to Agiliti Surgical before cases can be scheduled.
Applications should be emailed to: sscarbillingsupport@agilitihealth.com

TRADE NAME AND ADDRESS (Ship to Name)

FIRM LEGAL NAME (Bill to Address)

City _____
State _____ Zip(9 Digit Please) _____
County _____
Phone (_____) _____
Fax (_____) _____

City _____
State _____ Zip(9 Digit Please) _____
County _____
Phone (_____) _____
Fax (_____) _____
HIC # _____
GPO Name _____

UHS Account #: _____

Current customers of our parent company, Agiliti Health, Inc., may skip to signature block after completion of the above.

PLEASE CIRCLE ONE:

Corporation

Partnership

Sole Proprietorship

OFFICERS OR OWNERS

TITLE

PHONE NUMBER

PERSON TO CONTACT REGARDING FINANCIAL MATTERS

NAME

TITLE

PHONE NUMBER

Type of Business _____
Date Business Started _____
Incorporated in State of _____

Tax Exempt: (Circle One) **YES NO**
Tax Exempt number _____
(Must attach valid Exemption Form)

TRADE CREDIT REFERENCES

Company Name	Account #	Phone #	City/State
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____

BANK REFERENCE

Bank Name	Account #	Phone #
_____	_____	_____

Bank Address _____ Bank Officer _____

The Applicant warrants the information supplied above to be true. The Applicant authorizes Agiliti Surgical, Inc. to investigate the references herein, statements or other data obtained from Applicant or from any other pertaining to the Applicant's credit and financial responsibility. The Applicant agrees to abide by the Standard Terms of Sale published regularly by Agiliti Surgical, as shown on Agiliti Surgical invoices, or by any other terms of sale upon which Agiliti Surgical and the Applicant should agree in writing. The Applicant agrees to pay interest on past due accounts the highest rate permitted by law, together with attorney's fees and all other costs and expenses incurred by Agiliti Surgical in collecting such accounts.

BY: _____ **DATE:** _____
(Type or Print Responsible Officer or Owner)

SIGNATURE: _____ **TITLE:** _____