Western Medical Inc.

CREDIT CARD AUTHORIZATION FORM

THIS AUTHORIZES WESTERN MEDICAL INC TO USE THIS CREDIT CARD NUMBER FOR PAYMENT OF CHARGES DUE WHEN INVOICE NOT PAID WITHIN TERMS.

Company name: _____

Name on card: _____

Address pertaining to card: _____

_____

City:_____ State: _____Zip:_____

Card #: _____

Card type (circle): VISA MC AMEX

Expiration Date: _____

In the event where the full invoice amount is not paid within terms (net 30), Western Medical reserves the right to apply the invoice amount to the credit card provided after 35 days (5 day grace period). Western will charge a fee equal to 2.5% of the invoice amount when the card is charged at the end of the 35 days.*

Authorized representative: _____ Position:_____

Signature: _____

Email address: _____

Phone:_____

Date: _____

PLEASE COMPLETE AND FAX TO 425-486-7152

Western Medical Inc

3801 Fruit Valley Rd, Suite D Vancouver, WA 98660 800-228-3152

www.westernmedicalinc.com

***No fee will be charged if a credit card is used when placing an order.**