NEW CUSTOMER APPLICATION

Registered Company Name:_____
DBA:_____
Class of Trade:_____

Billing Address: _____
City: _____ State: _____ Zip Code: _____
Phone:_____Email:_____

Shipping Address: _____
City: _____ State: _____ Zip Code: _____
Phone:_____Email:_____

Owner/Officer Name:_____
Authorized Buyer : _____
Accounts Payable Contact: _____
Accounts Payable Phone: _____ Fax:_____
Accounts Payable E-Mail Address: _____

LICENSE INFORMATION (Please send a copy of Licenses to info@astordrugs.com) State ☐
License #:_____ Expiration Date: _____
DEA #: _____ Expiration Date: _____
EIN#_____

PAYMENT METHOD (ACH Also Accepted)
Credit Card:_____(Amex, Mastercard, Visa) CVV Required:_____
Card Number: _____ Exp. Date: _____
Name on Card or Account: _____

Bank_____ Routing # _____Acct#_____

I hereby certify that the above information is correct. I agree to pay and authorize charges to my card for all open invoices.
The information included in this credit application is only for the use of Astor Drugs, Inc

Authorized Representative Name:
_____Title_____

Authorized Representative Signature: _____
Date: _____

Astor Pharmaceuticals LLC

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Astor Drugs