



CREDIT APPLICATION

(PLEASE RETURN BY FAX TO: 604-504-7576)

Company Name _____ Contact _____
 Billing/Address _____ Phone _____
 _____ Fax# _____
 _____ E-Mail _____

Principal Shareholders Name(s) _____
 Nature of business _____
 Length of time in business _____
 Credit Limit Required Cdn. \$ _____

Credit Card Type _____
 Credit Card # _____
 Expiry Date _____

Credit References (non-related)

Name	Address	Phone#	Fax#
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____

I _____, the undersigned authorize the release of any information required by the above creditor in order to satisfy credit requirements, and that all credit issued becomes the joint obligation of the above listed applicant and the undersigned.

 Signature Date Print Name & Title

We value your business!
 Please tell us how you heard about us:

Note: Our payment terms are Net/15.

33771 George Ferguson Way PO Box 8000 Abbotsford BC V2S 6H1
 Tel: (604) 504-7575 Fax: (604) 504-7576