An FDA Registered Company

CREDIT APPLICATION AND AGREEMENT

Dear Sir or Madam:

Thank you for giving KAP MEDICAL an opportunity to serve you with your therapeutic support surface needs. Enclosed along with this letter is the credit application and agreement form, please complete, sign and return via fax or mail to our address listed below.

A copy of the Terms of Sale is also enclosed for your review.

If you have any questions, please feel free to call us at (866) KAPMED-1 (866 527 6331). Thank you once again for your interest in KAP MEDICAL products.

Best Regards,

Raj K. Gowda

1395 PICO STREET • CORONA, CALIFORNIA • 92881

TOLL FREE: 866-KAP-MED1 (866 527 6331) •FAX: 951-340-4361•EMAIL: SALES@KAPMEDICAL.COM• WWW.KAPMEDICAL,COM

An FDA Registered Company

CREDIT APPLICATION AND AGREEMENT

Company Name: _____

Billing Address: _____

Shipping Address: _____

Phone Number _____ Fax Number _____

Name of Parent Company (if subsidiary) _____

Legal Entity: □ Sole Proprietorship □ Partnership □ Corporation □ Limited Liability Company

□ Other_____ Tax I.D. / EIN # _____

Doing Business As An Individual, Social Security # _____

Date Business Established:_____ State of Incorporation: _____

Have you done business with KAP MEDICAL in the past? [ ] Yes [ ] No, D&B #_____

Under Another Name: □ Yes □ No, If yes, What Name: _____When_____

AP Contact Name: _____ Resale Certificate Number:_____

Owner/Officer Information			
Name	**Title**	**Address**	**Telephone #**
1.			
2.			
3.			
4.			

Bank References			
Bank Name	**Address**	**Telephone #**	**Account #**
1.			
2.			
3.			
4.			

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Supplier Credit Information			
Name	**Address**		
1.			
	Zip:	**Phone #:**	**Fax #:**
2.			
	Zip:	**Phone #:**	**Fax #:**
3.			
	Zip:	**Phone #:**	**Fax #:**

This Information is given for the purpose of obtaining products from KAP MEDICAL on credit. The information provided is warranted to be true. I / We authorize KAP MEDICAL and any assignee, lender, or funding service to be utilized to obtain and use a consumer credit report on the undersigned, now and from time to time, as may be needed in the credit evaluation review process and waives any right or claim that they would otherwise have under the Fair Credit Reporting Act in the absence of this continuing consent. And also authorize KAP MEDICAL to investigate supplier credit references and bank account information pertaining to my / our credit and financial responsibility. The applicant further agrees that the seller may report applicant's credit history with seller to any person, business or entities that may make inquiry with regard thereto. It is understood that this information will be strictly confidential.

Terms Desired: □ Net 30 days □ Prepaid □ C.O.D. Check

The undersigned acknowledges to pay for all goods purchased in compliance with KAP MEDICAL terms of sale. Each credit purchase will be subject to the following conditions: All delinquent invoices are subject to a service charge of 1.5% per month until paid.

If at any time, for any reason, the undersigned is unable to pay for said purchases when due, and in the event it becomes necessary for KAP MEDICAL to incur collection costs or institute suit, the undersigned and /or guarantor (s) promise (s) to pay reasonable attorney's fees, and collection costs if the account is placed in the hands of an attorney for collection.

The undersigned agrees that title to all goods purchased from Seller shall remain with Seller until payment in full has been received. Applicant further grants to Seller a continuing security interest in all goods purchased from Seller to secure the payment of all amounts due from applicant to Seller. To protect this security interest, applicant hereby appoints Seller, and any of Seller's designated employees or officers, applicant's attorney-in-fact ("Attorney-In-Fact") to execute and file any all UCC financial statements, and continuations thereof, in any jurisdictions in which Seller's goods or merchandise may be possessed by applicant.

The undersigned agrees to unconditionally guarantee payments of all sums owed pursuant to this agreement. This is intended to be and is a continuing guarantee and shall not be revoked except by written notice to KAP MEDICAL. The undersigned unconditionally and irrevocably submits to the exclusive jurisdiction of any court of competent jurisdiction located in Riverside County, California for the resolution of any claim or dispute hereunder.

Owner/Partner/Authorized Officer: _____
(Personal Guarantor)

Title: _____ Date _____

KAP MEDICAL Office Use Only: □ **Accepted** □ **Rejected** **Customer Account ID #:**_____

Approved By: **Date:** **Credit Limit: $** _____

TERMS OF SALE

Order Policy:

- $ 100.00 minimum opening order for new accounts.

Payment Terms:

- First order is wire transfer, prepaid or COD.
- Net 30 days upon credit approval.
- Accounts over 30 days past due are subject to a service charge of 1.5% per month until paid.
- A $ 50 bank fee will be charged for all return checks.
- Purchaser agrees to pay in accord with the terms of sale and further agrees to pay reasonable attorney's fees, and all collection costs if the account is placed in the hands of an attorney for collection.

Freight Policy:

- FOB KAP MEDICAL.
- Unless shipping method is specified on the purchase order, KAP MEDICAL will determine the freight carrier and include shipping charges on the invoice.
- If freight carrier and the account number are listed on the purchase order, KAP MEDICAL will use the listed freight carrier and the account number to ship products.
- Other than UPS, FedEx, or Golden State Overnight, all other freight carriers will be prepaid.

Return Policy:

- All returned products must have a RPA (Return Product Authorization) number assigned by KAP MEDICAL.
  All new products (unused) must be returned within 30 days of receipt. Product must be packaged properly in its original packaging material and shipped to KAP MEDICAL.
- Products damaged during shipping must be immediately (see product policy below) reported to KAP MEDICAL and shipped back within 5 days of receipt for replacement.

KAP MEDICAL Policy:

- KAP MEDICAL reserves the right to increase prices and improve, update or modify products without prior notification.

Product Liability:

- Product Liability Insurance certificate available upon request.

Warranty:

- Refer to Operating Instructions or contact KAP MEDICAL for more information.

Product Policy:

- All purchased products upon receipt must be examined for shipping damage or other defects and notify KAP MEDICAL within 5 days. If product was damaged during shipping please leave the product in its original packaging and notify freight carrier driver if possible before signing and accepting the package(s). Notify KAP MEDICAL immediately so we can call freight carrier to inspect the damaged package(s).