Account Set-up form for ORION Medical Supply

Business Name ________________________________

Phone # __________________________________

Fax # ___________________________________

Cell # ___________________ email address ___________________________

Cell Phone # and Email address are requested to ensure we can communicate with you when important. You will not receive SPAM calls or emails from ORION Medical Supply.

Ship to Address: ____

City______________________ State_____ Zip _________

(Mark One) Ship to Address is a: ______ Commercial Building _____ Residential Building

**** If you would like the invoice mailed to a different address than the Ship To Address please provide the Billing Address:**

Billing Address: _________________________________

City ______________________ State ______ Zip __________

Purchasing Contact ___________________________ Phone _________________

Accounting Contact ___________________________ Phone _________________

Account to pay by (mark one and complete info if requested)

______ TERMS Net 30 days date of invoice

______Credit Card : Card #______________________________

Card Expire Date __________ V-Code ______

_____ I will call you with my Credit Card information

**** Include a copy of any of your applicable Licenses for products to be ordered.**

I agree to abide by the general Terms & Conditions of ORION Medical Supply

Print Name _______________________

Sign Name ____________________________ Date ________

Scan & email along with licenses to : cs@orionmed.com or Fax to: 800-914-9220

Form submitted via orionmed.com