

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