

BioFire Diagnostics Distributor Credit Application Form

Please fill out this application completely and return it to our accounts manager

Please Submit Application to:

Email: newaccounts@biofiredx.com

Fax: (801) 588-0507

Phone: (801) 736-6354

General Business Information (Complete all fields.)		Parent/Affiliated Companies (if applicable)	
Legal Business Name		Parent/Affiliated Companies (if applicable)	
Business Name:		Business Name:	
Street Address:		Street Address:	
City:	State: Zip:	City:	State: Zip:
Phone #: () -		Phone #: () -	
Fax #: () -		Fax #: () -	
Web Address:		Web Address:	
Federal Tax ID #: _____ Dun & Bradstreet ID #: _____ DBA, if any: _____ VAT#, if any: _____ (Note: If applicable, copy of reseller or tax exemption certificate required.)			
Type of Business: <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> Govt. Agency <input type="checkbox"/> Other _____ <input type="checkbox"/> Public <input type="checkbox"/> Private <input type="checkbox"/> Public Univ/Coll <input type="checkbox"/> Private Univ/Coll			
Years in Business: _____ Year of Inc.: _____ State of Inc: _____			
Credit Requested \$: _____		Terms (Net 30 standard): _____	
Are Purchase Orders Used? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Name of person responsible for purchasing: _____		Telephone: _____ Email: _____	
Name of person responsible for accounts payable: _____		Telephone: _____ Email: _____	

Name of Owners, Partners, or Officers and Titles if Incorporated (Complete all fields and provide at least one owner, partner or officer.)			
Name:		Name:	
Title:		Title:	
Phone #: () -		Phone #: () -	
Email:		Email:	

Distributor Trade Reference Information (Please provide information of at least three companies you represent / distribute for.)			
Name:		Name:	
Contact Person:		Contact Person:	
Address:		Address:	
City:	State: Zip:	City:	State: Zip:
Phone #: () -		Phone #: () -	
Fax #: () -		Fax #: () -	
Email:		Email:	
Account #:		Account #:	
Name:		Name:	
Contact Person:		Contact Person:	
Address:		Address:	
City:	State: Zip:	City:	State: Zip:
Phone #: () -		Phone #: () -	
Fax #: () -		Fax #: () -	
Email:		Email:	
Account #:		Account #:	

Distributor Bank Reference Information (Complete all fields and provide at least one reference.)**Bank Name:**

Contact Person: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone #: () - _____
Fax #: () - _____
Email: _____
Checking Acct #: _____
Savings Acct #: _____
Loan Officer: _____
Loan #: _____

Bank Name:

Contact Person: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone #: () - _____
Fax #: () - _____
Email: _____
Checking Acct #: _____
Savings Acct #: _____
Loan Officer: _____
Loan #: _____

This application is submitted for the purpose of obtaining credit with BioFire Diagnostics, Inc. and is warranted to be true. By signing this application the undersigned acknowledges that he/she is authorized to execute this application and to obligate the company to make payment in full for all amounts due according to invoice on or before the net due date. Additionally, the undersigned will be responsible for all collection costs and attorney fees, with or without lawsuit, in order to collect any delinquent moneys. The undersigned hereby authorizes BioFire Diagnostics, Inc., Incorporated to make such inquiries (corporate/personal) as are necessary to obtain credit information and authorizes the bank(s) of record to release information regarding accounts.

Signature of Authorized Owner, Partner or Corporate Officer Required.

Please include current financial statements. Personal financial statements for all owners/officers must be furnished for companies in existence less than two years. Upon credit approval, the undersigned agrees to terms of **NET 30 DAYS**.

Signature of Owner, Partner or Corporate Officer**Date****Printed Name of Signer****Title**

BioFire Diagnostics Distributor Blanket Sales Tax Exemption Certificate

Please fill out this application completely and return it to our accounts manager
(MULTI-JURISDICTION)

Please Submit Application to:
Email: newaccounts@biofiredx.com
Fax: (801) 588-0507
Phone: (801) 736-6354

Issued to: BioFire Diagnostics, Inc.
390 Wakara Way
Salt Lake City, Utah 84108

* Name of Firm (Buyer): _____

* Street Address or P.O. Box Number: _____

* City: _____ * State: _____ * Zip: _____

* Buyer is Engaged as a Registered: ☐ Wholesaler ☐ Retailer ☐ Lessor ☐ Manufacturer
☐ Other: _____

and is registered with the below listed state(s) where your firm would deliver purchases to us and that any such purchases are for wholesale, resale, ingredients or components of a new product to be resold, leased or rented in the normal course of our business. We are in the business of wholesaling, retailing, manufacturing, leasing (renting) the following:

<u>State</u>	<u>Registration #</u>	<u>State</u>	<u>Registration #</u>	<u>State</u>	<u>Registration #</u>
AL	_____	MA	_____	PA	_____
AR	_____	MD	_____	RI	_____
AZ	_____	ME	_____	SC	_____
CA	_____	MI	_____	SD	_____
CO	_____	MN	_____	TN	_____
CT	_____	MO	_____	TX	_____
DC	_____	MS	_____	UT	_____
FL	_____	NC	_____	VA	_____
GA	_____	ND	_____	VT	_____
IA	_____	NE	_____	WA	_____
ID	_____	NJ	_____	WI	_____
IL	_____	NM	_____	WV	_____
IN	_____	NV	_____	WY	_____
KS	_____	NY	_____		
KY	_____	OH	_____		
LA	_____	OK	_____		

(*) We will need a copy of each State Certificate attached with this application.

I further certify that if any property so purchased tax free is used or consumed by the firm as to make it subject to a Sales or Use Tax, we will pay the tax due direct to the proper taxing authority when state law so provides or informs the seller for added tax billing. This certificate shall be part of each order which we may hereafter give to you, unless otherwise specified, and shall be valid until cancelled by us in writing or revoked by the state.

General Description of Products to be Purchased from Seller:

Under penalties of perjury, I swear or affirm that the information on this form is true and correct as to every material matter.

* Authorized Signature: _____

* Title: _____ * Date: _____

BioFire Diagnostics

Distributor Authorization to Release Credit Information

Please fill out this application completely and return it to our accounts manager

Please Submit Application to:

Email: newaccounts@biofiredx.com

Fax: (801) 588-0507

Phone: (801) 736-6354

In consideration of an open account arrangement with BioFire Diagnostics, Inc., I hereby authorize you to release information to BioFire Diagnostics, Inc. regarding credit history, checking and savings accounts, and/or loan experience. Thank you for your cooperation.

Legal Name of Company _____

DBA, if any _____

Authorized Signature _____

Title _____

Date _____