



**MASTER DISTRIBUTOR – WHOLESALE ONLY
Janitorial Foodservice Industrial Healthcare**

CREDIT APPLICATION

Return via Fax to: 614-836-0119

Please mail the original, signed documents to
Client Acquisition Services
Willis Distributing, Inc.
4600 Homer Ohio Lane
Groveport, OH 43125

Date: _____ Email Address: _____ Fax Number: _____.

Please check your preference: Advanced Certified Funds Credit Card Net 30

Estimated monthly sales: _____

Buying Group Member: Yes No If Yes, Name of Group: _____

I (we) do hereby apply for extension of credit. The following information is submitted in confidence.

Legal Name of Company: _____.

BILL TO: _____

CITY/STATE: _____ ZIP: _____.

PHONE: _____ FAX: _____

CONTACT NAME: _____

SHIP TO: _____

CITY/STATE: _____ ZIP: _____.

PHONE: _____ FAX: _____

CONTACT NAME: _____.

YEAR ESTABLISHED: _____ CORPORATION PARTNERSHIP PROPRIETORSHIP LLC

PRINCIPAL OWNERS OR OFFICERS

	NAME	TITLE	HOME ADDRESS	CITY	STATE	TELEPHONE
1.	_____	_____	_____	_____	_____	_____
2.	_____	_____	_____	_____	_____	_____
3.	_____	_____	_____	_____	_____	_____

REFERENCES

	BANK	CHECKING ACCT. #	STREET ADDRESS	CITY	STATE
1.	_____	_____	_____	_____	_____

BANK OFFICER _____ TELEPHONE _____

	MAJOR TRADE SUPPLIERS*	ACCT. #	TELEPHONE FAX
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____

*Please list only accounts with which you have CURRENT open credit terms (no COD)
A CURRENT FINANCIAL STATEMENT MUST BE SUBMITTED IN ORDER TO QUALIFY FOR CREDIT APPROVAL.
If credit is extended I/we agree to pay all debts incurred within the terms of sale. However, should the debt become past due I/we expressly agree (subject to statutory regulations) to pay finance charges on the past due amounts at the rate of 1½ % per month (18% annual rate); provided that no provision of this agreement requires or permits the collection of finance charges in excess of the maximum amount permitted by law. I/we further agree to pay reasonable collection costs and/or attorney's fees incurred in connection with the collection of this account.

THIS APPLICATION MUST BE SIGNED BY AN OFFICER OR PRINCIPAL OF THE COMPANY IN ORDER TO BE PROCESSED.

Owner Social Security Number / /

SIGNATURE: _____ PRINTED NAME: _____

TITLE: _____ DATE: _____

4600 Homer Ohio Lane Groveport, OH Phone 800-423-2889 Fax 614-836-0119