



# Account Application

761 Harris Street Jackson, MS 39202  
Phone: (601)353-1307 or 1-800-624-6744 Email: orders@opticaldistributors.com  
Fax: (601)353-1505 or 1-866-353-1505

## Account Information

Name of Applicant	
Name of Legal Entity	
Bill-To Address (statement mailed here or will emailed to email address below)	
City / State / Zip	
Set as Primary Ship To?	Yes <input type="radio"/>
Ship-To Address (if different than above)	
City / State / Zip	
Set as Primary Ship To?	Yes <input type="radio"/>
Business Phone	Business Fax
Contact Person	Email
Email for AP	
Email for contact	

## Business Organization

OD	MD	Lab	Optician	Retailer	Date
Formed Sole Proprietor	Partnership	Corporation	LLC	PA	
Federal Tax ID					
Business Owner #1	Email				
Business Owner #2	Email				

## Trade References

Reference	Account #	Phone
Reference	Account #	Phone
Reference	Account #	Phone

## Required Signature

I authorize Optical Distributors, Inc. to obtain credit information from the above listed references and from any credit-reporting agency. I have read the terms and conditions and acknowledge such terms and conditions govern my relationship with Optical Distributors, Inc. My signature below indicates acceptance of and agreement to terms and conditions and my guarantee of buyer's obligation. It is further understood and agreed that should this account not be paid to terms, the undersigned will pay interest at the highest rate allowed by law in the State/County business resides. This is Jackson, MS, Hinds County. If the account is turned over to collection, I accept and will pay reasonable attorney or collection fees.

Print Name	Title
Signature	Date



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## Credit Terms Application

### Company Information

Company Name: \_\_\_\_\_

Company Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Key Contact Person: \_\_\_\_\_ Accounts Payable Contact Person: \_\_\_\_\_

Telephone Number ( ) \_\_\_\_\_ Fax Number ( ) \_\_\_\_\_

Federal Tax ID / EIN: \_\_\_\_\_

### Banking Information

Bank: \_\_\_\_\_ Branch: \_\_\_\_\_ Acct #: \_\_\_\_\_

Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Phone \_\_\_\_\_

### Credit References

Company Name \_\_\_\_\_ Company Name \_\_\_\_\_ Company Name \_\_\_\_\_

Contact Name \_\_\_\_\_ Contact Name \_\_\_\_\_ Contact Name \_\_\_\_\_

Address \_\_\_\_\_ Address \_\_\_\_\_ Address \_\_\_\_\_

City \_\_\_\_\_ City \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone # ( ) \_\_\_\_\_ Telephone # ( ) \_\_\_\_\_ Telephone # ( ) \_\_\_\_\_

Fax # ( ) \_\_\_\_\_ Fax # ( ) \_\_\_\_\_ Fax # ( ) \_\_\_\_\_

The undersigned affirms that the above credit information is true and correct and is given for the extension of credit by Optical Distributors, Inc. I/We agree to pay the late charges on any unpaid account after payment terms of 30 days at the rate of 1.5% per month or the highest rate allowed by law. Should the account be placed for collection, the undersigned agree to pay all actual collection costs and attorney's fees., Hinds County Court of Jackson, MS will be court of venue. I hereby authorize the release of information to obtain credit with Optical Distributors, Inc.

Name \_\_\_\_\_ Signature \_\_\_\_\_ Title \_\_\_\_\_ Date \_\_\_\_\_

Name \_\_\_\_\_ Signature \_\_\_\_\_ Title \_\_\_\_\_ Date \_\_\_\_\_

Privacy Statement: The above information provided is for Optical Distributors, Inc use only and will be kept confidential at all times.