PATTERSON® DENTAL

FLORIDA CUSTOMER APPLICATION

*Date_____*Branch Name/Number_____

*Territory Rep Name_____ *Legacy Territory#_____

*SAP Territory#_____

Payment Cycle (Select One): ☐ Remit (Default) ☐ Balance Forward (Select one): ☐ Due on 1st ☐ Due on 15th

Fields marked with "*" are required for set up. In order to avoid processing delays, application must be completed in full.

***TRADE CLASS:** (*Pick one*) ☐ Doctor ☐ Group ☐ Institution ☐ Lab ☐ Hygienist ☐ Student ☐ Other

SPECIALTY CODE: (*Pick one*) ☐ Endodontist ☐ Orthodontist ☐ Oral & Maxillofacial ☐ Pediatric ☐ Periodontist ☐ Prosthodontist

*PO Required? ☐ Yes ☐ No

1. PRACTITIONER INFORMATION FROM STATE OF FLORIDA FOR PHARMACEUTICAL SHIPMENTS

Practitioner Name (As licensed by the State of Florida)_____

Practitioner Lic. No. _____ Expiration Date _____

2. HEALTH CARE CLINIC ESTABLISHMENT (HCCE) INFORMATION FROM STATE OF FLORIDA FOR PHARMACEUTICAL SHIPMENTS

HCCE Name & Lic. No. (As Licensed by the State of Florida)_____Expiration Date:_____

Qualifying Practitioner Name & Lic. No._____Expiration Date:_____

SHIPPING INFORMATION (As licensed by the State of Florida)

* Address _____

* City_____* State _____* ZIP _____ -_____

County _____*Business Phone _____

OK to ship via U.S. Mail? ☐ Yes ☐ No Fax # _____

BILLING INFORMATION (Party responsible for payment)

* Name _____ * Social Security Number_____

* Address _____

* City_____ * State_____* ZIP_____-_____

* Phone _____ * Email _____

* If additional accounts exist, please list account number(s):_____ ☐ I would like online account access and have registered the above email address on Pattersondental.com.

*** Sales Tax Status** (please check one)

☐ **NOT EXEMPT** -A signed Statement of Sales Tax Liability must be attached to this application to claim this.

☐ **EXEMPT** - A fully completed tax exemption/resale certificate MUST BE attached to this application to claim this.

This Customer Application ("Application") is submitted for the purpose of opening a commercial account credit with Patterson Dental Supply, Inc. (PDSI). I authorize PDSI to verify the information on this Application and to receive information about me, including requesting reports from consumer reporting agencies. I further authorize PDSI and its affiliates to contact these sources at any time. I represent that all purchases from PDSI and its affiliates shall be for business and commercial purposes only. I understand that I will receive statements monthly and that the payment terms are "due upon receipt" of statement. I further understand that PDSI may impose a service charge of up to 1½ % per month on amounts delinquent beyond the date specified on the statement. In the event of default, the undersigned agrees to pay all costs of collection including reasonable attorney's fee and court costs. I agree that any dispute hereunder or with PDSI shall be governed by Minnesota law and the venue in Dakota County, Minnesota. Regardless of whether the signature(s) on this Application indicate(s) a representative capacity, the individual(s) signing this Application agree(s) to be personally responsible for payment of the account.

I authorize and give permission and my power of attorney to any agent, employee or representative of my business (collectively "Agent"), whether or not such Agent's relationship to me is shown, to execute an Automated Clearing House ("ACH") request for sums due to PDSI on my behalf, in Agent's name or in my name (Not Applicable to Institution Trade Class). I represent to PDSI and its affiliates that it may rely on the signature of my Agent on the ACH request forms. I hereby hold PDSI and its affiliates harmless and indemnify it from all liabilities, losses, damages or claims arising from such signature by my Agent.

Notice: The federal Equal Credit Opportunity Act prohibits creditors from discriminating against credit applicants on the basis of race, color, religion, national origin, sex, marital status, age (provided the applicant has the capacity to enter into a binding contract); because all or part of the applicant's income derives from any public assistance program; or because the applicant has in good faith exercised any right under the Consumer Credit Protection Act. The federal agency that administers compliance with this law concerning this creditor is FDIC, 2345 Grand Avenue, Kansas City, MO 64108.

I HAVE READ THIS AGREEMENT AND AGREE WITH ITS TERMS.

*Signature _____

Date_____

C/O use only

Approved by _____ Date _____

For additional information on Health Care Clinic Establishment permits for Rx drug purchases please visit:
http://myfloridalicense.custhelp.com/app/answers/detail/a_id/2294/kw/do%20dentist%20need%20Healthcare%20clinic%20establishment

Please submit your completed application AND tax documentation
By email to: newcustomersupplyaccount.applications@pattersoncompanies.com Or via FAX to : 651.688-3064

1031 Mendota Heights Road
Saint Paul, MN 55120

Statement of Sales Tax Liability

ONLY COMPLETE THIS FORM IF YOU WISH TO BE TAXED ON ALL PURCHASES FROM PATTERSON DENTAL SUPPLY

1. I understand by signing this form that I am claiming no tax exemptions apply to my purchases from Patterson Dental Supply, except those given by state statute.

2. In signing this form, I understand that Patterson Dental Supply will not credit any sales tax back to me or my account on previous purchases if I choose to change my status.

3. If I choose to change the tax status on my account with Patterson Dental Supply, I will sign the appropriate tax exemption certificate and the applicable tax exemptions will apply to my account as of the date the form is received by Patterson Dental Supply. The exemptions will apply only to the state(s) for which I complete and sign an exemption certificate.

Please contact a professional tax advisor if you have any questions about your business and tax liability.

Customer Name _____

Signature _____

Address _____

City _____ State _____ Zip _____

Date _____