



Drug Wholesaler Credit Application
Fax to (330) 528-0423

CUSTOMER NAME _____

OWNER: _____

CONTACT: _____

PHONE # _____ FAX # _____

SALESPERSON: _____

SHIP TO: _____

DRUG WHOLESALER BILL THRU INFORMATION:

DRUG WHOLESALER NAME _____

DRUG WHOLESALER DIVISION _____

DRUG WHOLESALER ACCOUNT # _____

DRUG WHOLESALER CONSULTANT _____

BUSINESS SALES TAX # _____

CORPORATION NAME: _____

AUTHORIZED SIGNATURE _____

DATE: _____

TO BE COMPLETED BY ICM PERSONNEL

PRICE TICKETS: YES ___ NO ___ RETAIL: ICM ___ SPEC ___

BREAK PACK: YES ___ NO ___