Abbott Lingo Credit Application

US: Email completed form to sales-us@hellolingo.com

* Indicates a Required Field

* Request Type

☐ New Abbott Account
☐ New Ship-To Account (*Must enter Bill-To Account Number)

* Bill-To Account Number:

Bill-To Information

* Full Legal Name of Entity Responsible for Debit:
Years in Business:
* PO Box/Street Address:
* City & State/Province:
* Zip/Postal Code :
* Country:
* Contact Name:
* Title:
* Phone
* Email:
GLN:

Ship-To Information

* Full Legal Name of Entity Responsible for Debit:
Years in Business:
* Street Address:
* City & State/Province:
* Zip/Postal Code :
* Country:
* Contact Name:
* Title:
* Phone
* Email:
GLN:

Customer Company Details

Parent Company:
Full Address:
Contact Name:
Phone:
Email:

Accounts Payable Contact Name:
Phone:
Email:

Purchasing Contact Name:
Phone:
Email:

* CUSTOMER TYPE

☐ Corporation ☐ Partnership ☐ Sole Proprietorship ☐ Limited Liability ☐ Other - Please Explain

* CUSTOMER CLASS OF TRADE

☐ Clinical Trials
☐ County Health System
☐ Employer/Employee Group
☐ Employee Health & Wellness Provider
☐ Government
☐ Health Plan
☐ Hospital
☐ Integrated Health System
☐ Laboratory
☐ Mail Order / DME
☐ Medical Group / Independent Phy. Association
☐ Nursing Home / Long Term Care
☐ Pharmacy
☐ Physician's Office/Healthcare Professional Practice (HCP)/Clinic
☐ Post Acute Care Distributor
☐ Retailer
☐ Wholesaler/Distributor
☐ Other (Provide description)

State & Federal Tax Status

☐ Taxable * Federal Tax ID:
☐ Exempt (State Tax Exemption Certificate must be attached to application)

Credit Information

Primary Bank

Bank Name:
Full Address:
Contact Name:
Phone:
Account Number:

Credit References

Name:
Full Address:
Contact Name:
Phone:
Account Number:

☐ * Customer Acknowledgement (Required)

CUSTOMER HEREBY AUTHORIZES THE BANK REFERENCES LISTED HEREIN TO RELEASE ALL INFORMATION REQUESTED. CUSTOMER AGREES THAT ALL AMOUNTS THAT ARE PAYABLE ON OR BEFORE THE NET DUE DATE, AS SHOWN ON EACH INVOICE, WILL BE PAID BY SUCH DATE, AND, IF NOT PAID ON OR BEFORE SUCH DATE ARE THEN DELINQUENT. IF CUSTOMER'S ACCOUNT IS PLACED FOR COLLECTION, CUSTOMER AGREES, IN ADDITION TO THE PRINCIPAL AMOUNT OWED, TO PAY COLLECTION AND/OR ATTORNEY FEES OF 25% OF THE DELINQUENT AMOUNT. CUSTOMER FURTHER AGREES THAT ANY CONTROVERSY ARISING IN ANY DEALINGS BETWEEN THE PARTIES SHALL BE GOVERNED BY AND INTERPRETED IN ACCORDANCE WITH THE LAWS OF THE STATE OF ILLINOIS AND, AT ABBOTT'S OPTION, TO SUBMIT TO THE JURISDICTION OF THE COURTS (STATE OR FEDERAL) LOCATED IN THE STATE OF ILLINOIS.

I HEREBY ATTEST TO THE ACCURACY OF THE INFORMATION ENTERED UPON THIS APPLICATION. FURTHER, I CERTIFY THAT THE NAME, ADDRESS, DEA REGISTRATION NUMBER AND SCHEDULES ENTERED ON OR ATTACHED TO THIS FORM ARE IDENTICAL TO THE INFORMATION LISTED ON MY CURRENT FEDERAL DEA REGISTRATION CERTIFICATE. I HEREBY AGREE TO IMMEDIATELY NOTIFY ABBOTT LABORATORIES OF ANY CHANGE OF OWNERSHIP, NAME, ADDRESS, DEA REGISTRATION, DEA STATUS, STATE PHARMACY LICENSE NUMBER, OR STATE TAX STATUS.

* Name of Authorized Representative:
* Title:
* Print Name:
* Date:
* Phone:
* Email: