DESIGN VERONIQUE®

New Account Application

Hospital/Clinic Name				
Doctor/Propieter Name		**Sales Tax ID#**		
(Billing)Address		City	State	Zip
Contact Person	E-mail	Website		
Phone Number	Fax	Other		

How did you hear about Design Veronique?

Shipping Address (same as above ☐)

Address Line 1			
Address Line 2	City	State	Zip

PREFERRED METHOD OF PAYMENT

☐ **Bill Credit Card (Your CC will be charged after every order.)** We accept; Visa, MasterCard, Discover, and AmericanExpress.

Card Type	Card Number	Expiration Date
Name on Card	Card Holder's Autherizes Signature	

☐ **Net 30 (You will be billed after each order is shipped and payment is due within 30 days of invoice date.)**

*Monthly statements are mailed at the beginning of each month to all customers.

Name	Title
Signature	Date

Thank you for choosing to set up a New Account Application with Design Veronique. After completing you may fax this form back to **(510)970-7996**, or snap a clear picture of this form with your camera/smart-phone and email the image to either

cs@designveronique.com

or online at **https://www.designveronique.com/wholesale/apply** (linked in the QR-Code below).