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TherapeuticPillows.ca
IMPROVE YOUR SLEEP! PH: 905-783-5699

Send Form To:
905-593-1615 (fax)
hello@therapeuticpillows.ca

BUSINESS PARTNERSHIP APPLICATION

BUSINESS CONTACT INFORMATION

Contact Name & Title:

Company name:

Phone: Fax: E-mail:

Registered company address:

City: State: ZIP Code:

Date business commenced:

Sole proprietorship: Partnership: Corporation: Other:

BUSINESS AND CREDIT INFORMATION

Primary business address:

City: State: ZIP Code:

How long at current address?

Telephone: Fax: E-mail:

Bank name: Contact:

Bank address: Phone: Fax:

City: State: ZIP Code:

Type of account Account number

Savings

Checking

Other

BUSINESS/TRADE REFERENCES

Company name:

Address:

City: State: ZIP Code:

Phone: Fax: E-mail:

Type of account:

Company name:

Address:

City: State: ZIP Code:

Phone: Fax: E-mail:

Type of account:

Company name:

Address:

City: State: ZIP Code:

Phone: Fax: E-mail:

Type of account:

AGREEMENT

Claims arising from invoices must be made in writing within seven working days.

1. By submitting this application, you authorize to make inquiries into the banking and business/trade references.
2. All invoices are to be paid 30 days from the date of the invoice. Unpaid invoices are subject to additional 1.5% fees per month.
3. Responsible parties agree to assume all reasonable expenses incurred should the account have to be referred for collections to an Agency and or an Attorney.

SIGNATURES

Title: Date: Title: Date: