

Buyer Application – Easy Pay

Please return to DOTmed either by faxing to (212) 742 1202 or scanning and emailing to
info@dotmed.com

Sole Proprietorship Partnership Corporation LLC

Company Name _____

Contact _____ EIN _____

Address _____ City _____ State _____ Zip _____

Business Phone _____ Business Fax _____

Bank Reference

Name of Bank _____

Address _____ City _____ State _____ Zip _____

Business Phone _____ Business Fax _____

Checking Account _____ Savings Account _____

Trade References

	Name	City/State	Account	Telephone
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____

The information above is true and complete and is submitted to DOTmed.com, Inc. for the purpose of securing credit.

I acknowledge and agree that the acceptance or rejection of this application creates no liability, to any party (including myself), under any theory of liability whatsoever, upon DOTmed or its affiliates, its shareholders, officers, directors, users and agents.

I acknowledge and agree that, any Transaction Amount approved by DOTmed may be decreased, increased or terminated by DOTmed, in its sole discretion, at any time, without creating any liability, to any party (including myself), under any theory

of liability whatsoever, upon DOTmed or its affiliates, its shareholders, officers, directors, users and agents.

I hereby authorize DOTmed to conduct a background check and other market investigations about me in order to process my application, including but not limited to, contacting my references, conducting an independent investigation, and verification of the information provided in my profile.

I acknowledge and agree all terms and conditions of www.dotmed.com that may be applicable to this application, including but not limited to Parts Hunter Easy Pay Terms.

Date _____ Signature _____ Title _____