Customer Billing Form

ACCOUNT INFORMATION: **ACCOUNT #:** _____ **SHIPPING #:** _____

	Shipping Address:	Billing Address:
Clinic Name:		
Address 1:		
Address 2:		
Address 3:		
City, State & Zip Code:		
Phone #:		
Fax #:		
Email Address:		
Contact Name:		

Billing Method: Choose Method

Payment Method: Choose Method

Billing Email: _____

*Fees are associated with this option, please see Terms & Conditions

Taxable Status: ◯ Taxable ◯ Non-Taxable **(If Non-Taxable, You Must Attach Tax Exempt Documentation)**

Tax ID: _____ Certificate # of Non-taxable ID: _____

Number of Locations: _____

Please Return Completed Form to custserv@rockwellmed.com.

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Customer Billing Form (Cont.)

ROCKWELL INTERNAL USE ONLY

Customer Type: Choose an Item

Contract Type: Choose an Item

End User Type: Choose an Item

Delivery Type: Choose an Item

Payment Terms: Choose an Item

Credit Limit: $

PRICING INFORMATION:

Contract Number: _____

Contract Effective Date: _____ Contract Expiration Date: _____

Special Terms: _____

CUSTOMER CARE:

Customer Number: _____

Ship-To Number(s): _____

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