

## POSTURE MEDIC DISTRIBUTOR APPLICATION

Thank you for your interest in becoming a distributor for Posture Medic.

### COMPANY PROFILE

<b>Company Name:</b>		<b>Country:</b>	
<b>Year Company Started:</b>	Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Government <input type="checkbox"/> Sole Proprietorship <input type="checkbox"/>		
<b>Telephone:</b>	<b>Fax:</b>	<b>Website:</b>	
<b>Years in Business:</b>	<b>Number of Employees:</b>	<b>Number of Sales People:</b>	
<b>Projected Revenue for this Year:</b>		<b>Last Year's Revenue:</b>	
<b>Type of Business:</b>	<input type="checkbox"/> Distributor	<input type="checkbox"/> Manufacturer	<input type="checkbox"/> Retail <input type="checkbox"/> Healthcare <input type="checkbox"/> Online
<b>Does the company have Distributors?</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<b>If so how many?</b>
<b>Does the company supply Retail Stores?</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<b>If so how many?</b>
<b>Does the company supply Clinics/Healthcare?</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<b>If so how many?</b>
<b>Does the company exhibit at Consumer Tradeshows?</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<b>If so how many?</b>
<b>Top 5 Current Products:</b>			
1. _____	2. _____	3. _____	4. _____
			5. _____

### TRADE REFERENCES

<b>Company Name:</b>	<b>Contact:</b>	<b>Annual Purchase:</b>
<b>Company Name:</b>	<b>Contact:</b>	<b>Annual Purchase:</b>
<b>Company Name:</b>	<b>Contact:</b>	<b>Annual Purchase:</b>

### COMPANY CONTACT INFORMATION

<b>Sales:</b>	<b>Phone:</b>	<b>Email:</b>
<b>Purchasing:</b>	<b>Phone:</b>	<b>Email:</b>
<b>Shipping/Logistics:</b>	<b>Phone:</b>	<b>Email:</b>
<b>Marketing/Graphics:</b>	<b>Phone:</b>	<b>Email:</b>

### APPLICANT INFORMATION

<b>Name of Applicant:</b>	<b>Phone:</b>
<b>Email of Applicant:</b>	<b>Date:</b>