

POSTURE MEDIC DISTRIBUTOR APPLICATION

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

COMPANY PROFILE

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

TRADE REFERENCES

Company Name:	Contact:	Annual Purchase:
Company Name:	Contact:	Annual Purchase:
Company Name:	Contact:	Annual Purchase:

COMPANY CONTACT INFORMATION

Sales:	Phone:	Email:
Purchasing:	Phone:	Email:
Shipping/Logistics:	Phone:	Email:
Marketing/Graphics:	Phone:	Email:

APPLICANT INFORMATION

Name of Applicant:	Phone:
Email of Applicant:	Date: