



# Distributor Application

U.S. Dealer  International Dealer

Company Name _____	Date Established: _____
Your Name _____ Title _____	Annual Sales \$ _____
Address _____	Federal ID# _____
_____	Resale Certificate # _____
City _____ State _____ Zip Code _____	Please submit a copy of your resale certificate issued by your state. Fax to: (201) 599-1406.
Country _____	
Telephone _____ Ext. _____ Fax _____	
E-Mail _____ Website _____	

**Ownership/Officers:**

President _____	Phone _____	Ext. _____	E-Mail _____
Vice President _____	Phone _____	Ext. _____	E-Mail _____
Chief Financial Officer _____	Phone _____	Ext. _____	E-Mail _____

**Important Contacts:**

Purchasing _____	Phone _____	Ext. _____	E-Mail _____
Accounts Payable _____	Phone _____	Ext. _____	E-Mail _____
Sales Manager _____	Phone _____	Ext. _____	E-Mail _____
Marketing Manager _____	Phone _____	Ext. _____	E-Mail _____

Primary product line:

Customer base: Distributors  Laboratories  Govt.  Doctors  Hospitals  Industrial  Other

Primary customers served: \_\_\_\_\_

Geographical area served: \_\_\_\_\_

List area competitors: \_\_\_\_\_

Do you currently purchase laboratory plasticware from other suppliers? Yes  No

If yes, what is your annual purchase amount \_\_\_\_\_

Who are your key suppliers of lab plasticware?

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

Globe Scientific products of interest: \_\_\_\_\_

Anticipated annual purchases of Globe products: \_\_\_\_\_

Means of promotion: \_\_\_\_\_

Number of outside sales representatives: \_\_\_\_\_

Number of inside telemarketers: \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Please Note: Credit terms may be provided to US/Canadian companies with at least one year of credit history with established companies in the medical, surgical or laboratory industries. A separate credit application is available upon request.

