# NEW CUSTOMER INFORMATION

## C.O.D. ACCOUNT

SALES PERSON

Please complete:
1.) The customer information below.
2.) The required state tax resale form.
3.) Please include a photo copy of your company's resale certificate and business card.

**Please return all of the above items via mail or fax. 508-672-1433.**

**(THIS IS NOT A CREDIT APPLICATION)**

DATE:_____

BUSINESS NAME:_____

**NATURE OF BUSINESS:**

- ❑ STOREFRONT RETAIL FLORIST
- ❑ GIFT / PARTY SHOP
- ❑ GARDEN CENTER
- ❑ FREE LANCE DESIGNER (HOME BASED BUSINESS)
- ❑ OTHER - EXPLAIN _____

LIST PRODUCTS TO BE PURCHASED:_____

SHOP ADDRESS:_____CITY:_____STATE:____ ZIP: _____

BILLING ADDRESS:_____CITY:_____STATE:____ ZIP: _____

SHOP TELEPHONE #: (  ) _____FAX #: (  ) _____

CONTACT PERSON:_____HOME PHONE: (  )_____

STATE TAX NUMBER OF BUSINESS:_____ BOOKKEEPER_____

E-MAIL ADDRESS: _____CHECK TO RECEIVE E-MAIL SPECIALS___

HOW LONG HAS SHOP BEEN IN BUSINESS? _____ BUSINESS HOURS to

HOW LONG HAVE YOU OWNED SHOP?_____REQUESTING DELIVERY?_____OR PICK UP?

YOUR BUSINESS HAS A COMMERCIAL STORE FRONT INCLUDING THE SHOP NAME ON A SIGN? YES___ NO ___

TYPE OF BUSINESS: PROPRIETORSHIP__ CORPORATION ___ PARTNERSHIP___

IF PROPRIETORSHIP: _____

PRINT OWNER'S NAME PRINT HOME ADDRESS SOCIAL SECURITY #

IF CORPORATION: _____

CORPORATE NAME PRINT MAJORITY SHAREHOLDER'S NAME

**IF PAYING BY CREDIT CARD, PLEASE COMPLETE:**

___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

_____ _____ _____ _____

EXPIRATION DATE CARD HOLDER'S NAME BILLING ZIP SECURITY CODE

**THIS DOES NOT CONFER CREDIT TERMS** TO THE CUSTOMER. HOWEVER THE CUSTOMER AGREES THAT ANY AMOUNT UNPAID FOR MORE THAN 30 DAYS WILL ACCRUE INTEREST AT THE RATE OF 1.5% PER MONTH WHICH THE CUSTOMER HEREBY CONSENTS TO AND AGREES TO PAY ALONG WITH ANY UNPAID BALANCE.
I AGREE, IF ANY CHECKS ARE DISHONORED OR RETURNED FOR ANY REASON, THE AMOUNT OF THE CHECK MAY BE ELECTRONICALLY DEBITED FROM MY BANK ACCOUNT PLUS A PROCESSING FEE OF $25. 00 (OR LEGAL LIMIT). THERE WILL ALSO BE A $20.00 SERVICE CHARGE FOR EACH RETURNED CHECK.

_____ _____ _____

PRINT NAME SIGNATURE REQUIRED DATE

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FOR OFFICE USE ONLY

CUSTOMER #: _____ DATE ENTERED:_____ BY: _____ APPROVAL:_____

SALESPERSON _____ ROUTE: _____ OPENED BY:_____