



DEALER APPLICATION

Estimated Amount Of Monthly Sales With Winco: \$ _____

Company Legal Name _____ Address _____

City _____ State _____ Zip _____ Phone # _____ A/P Contact _____

BUSINESS STRUCTURE

Fax # _____ FEIN# _____

Corp. State of Corp. _____ Proprietorship Partnership or LLC. Years in Business _____

Subsidiary Branch \Division? Yes No If Yes: Name\Address of Parent Co. _____

Has Business\Officer(s) filed for Bankruptcy? Yes No If Yes, When? _____

PRINCIPLES

President\CEO _____ Vice President/General Manager _____

CFO\Contoller _____ Purchasing Manager _____

Sales Manager _____ Marketing/ IT _____

Information required for all corporations in business less than 2 years and all proprietorships, partnerships or L.L.C.'s

Principal _____ Home Address _____

City _____ State _____ Zip _____ Phone _____ SSN _____

Principal _____ Home Address _____

City _____ State _____ Zip _____ Phone _____ SSN _____

BANK AND/OR LENDER REFERENCES

Name _____ Contact _____ Address _____

City _____ State _____ Zip _____ Ph _____ Fax _____ Acct. # _____

Name _____ Contact _____ Address _____

City _____ State _____ Zip _____ Ph _____ Fax _____ Acct. # _____

TRADE REFERENCES

Name _____ Contact _____ Phone _____ Fax _____ Acct. # _____

A current balance sheet and income statement should accompany this application.

I\We agree to make all payments with-in 30 days from invoice date if terms are established. If it becomes necessary to file a lien, suit or engage a collection agency or attorneys, I\We agree to bear all expenses incurred (whether or not a suit is filed) Including but not limited to attorney fees, court costs and interest at 1 \2 % per month (18% annum). I\We agree and acknowledge that venue shall be Marion county, Florida. I Understand that a personal guarantee may be required to establish an open account.

I hereby release any and all credit or financial information to Winco, Inc. for the purpose of establishing credit. By signing I am accepting Winco, Inc's Terms and conditions of sale.

Name (print) _____ Signature _____ Date _____

RETURN THIS APPLICATION TO:



DEALER VERIFICATION

Thank you for your interest in Winco's products. We are looking forward to providing you with our quality products. As a manufacturer, we can only sell our products to qualified dealers and/or re-sellers. Please complete this form and either mail or fax it back to Winco along with a copy of your license and resale certificate. Upon verification we will be happy to process your order or credit application.

I certify that _____

(dealer name)

located at _____

(address)

is a valid medical equipment dealer and is licensed to sell medical equipment.

A copy of your license and resale certificate must accompany this form for verification.

(signature)

(print name)

(date)

Falsifying any information will result in immediate closure of an established account and a request for immediate payment of any unpaid balances.

RETURN THIS VERIFICATION FORM TO:

5516 S.W. First Lane * Ocala, Florida 34474-9307

Phone (352) 854-2929 * Order Dept. (800) 237-3377 * Fax (352) 854-9544

Website: www.wincomfg.com * E-mail: customerservice@wincomfg.com



Dear Healthcare Equipment Provider,

On behalf of WINCO, I want to thank you for your desire to become one of our valued customers.

Enclosed please find the DEALER APPLICATION that you have requested for your company. Keep in mind that the length of time to approve your credit application often depends on how quickly WINCO receives the completed application and responses to follow up questionnaire. We encourage you to check back with WINCO if you have not heard from us in a reasonable amount of time.

In order to help serve our customers more effectively, please take a moment to answer the following questions. *By returning this questionnaire with your completed dealer application, it will expedite your application process.* This information will also let WINCO know if we are effectively reaching our customers with product and sales information that they need to know about.

We hope to hear from you soon!

Sincerely,
Susan Bartlett
Inside Sales Manager

WHO ARE YOUR TARGET MARKETS? %

- Hospitals
- Clinics
- Physicians Offices
- Chiro/Physical Therapy
- Long Term Care Facilities
- Home Care/ Mobility
- Bariatrics
- Schools/Institutions
- Other (Please specify) _____

HOW DO YOU DO BUSINESS?

- Field Reps (How many?) _____
- Inside Sales (How many?) _____
- Website (url?) _____
- Catalog (When is it mailed?) _____

Which of our products (product lines) do you intend to promote? _____

HOW DID YOU HEAR ABOUT WINCO? (PLEASE CHECK)

- 01 _____ Magazine Ad
- 02 _____ Internet
- 03 _____ Word Of Mouth Whom? _____
- 04 _____ Mailing
- 05 _____ Sales Representative Whom? _____
- 06 _____ Trade Show
- 07 _____ Previous Customer
- 09 _____ Product Catalog
- 10 _____ Other _____

Please return this form with your credit application OR fax back to (352) 854-9544