



**BUSINESS CONTACT INFORMATION**

Company legal name:

DBA (If any):

Phone:

Fax:

E-mail:

Registered company address:

City:

State:

ZIP Code:

Date business commenced:

Sole proprietorship:

Partnership:

Corporation:

Other:

**BUSINESS AND CREDIT INFORMATION**

Primary business address:

City:

State:

ZIP Code:

How long at current address?

Telephone:

Fax:

E-mail:

Bank name:

Bank address:

Phone:

City:

State:

ZIP Code:

**Accounts Payable Info**

Contact Name:

Phone:

Email:

**BUSINESS/TRADE REFERENCES**

Company name:

Address:

City:

State:

ZIP Code:

Phone:

Fax:

E-mail:

Company name:

Address:

City:

State:

ZIP Code:

Phone:

Fax:

E-mail:

Company name:

Address:

City:

State:

ZIP Code:

Phone:

Fax:

E-mail:

**AGREEMENT**

1. All invoices are to be paid 30 days from the date of the invoice.
2. Claims arising from invoices must be made within seven working days.
3. By submitting this application, you authorize Ideal Logistics Group to make inquiries into the banking and business/trade references that you have supplied.

**SIGNATURES**

Title:

Title:

Date:

Date:

Please fax the completed application to 905-636-7801