ILIULIUK

Iliuliuk Family and Health Services, Inc.

Unalaska/Dutch Harbor Community Medical Center

P.O. Box 144
Unalaska, Alaska 99685

Phone: (907) 581-1202
Fax: (907) 581-2331

BUSINESS CREDIT APPLICATION

BUSINESS NAME: _____

ADDRESS: _____

_____

TELEPHONE: _____ FAX: _____

TYPE OF BUSINESS: _____

CONTACT FOR ACCOUNTING PURPOSES: _____

CONTACT FOR EMERGENCIES **(24 hrs/day)**: _____

CONTACT PHONE # **(24 hrs/day)**: _____
(If no one is available 24 hrs/day, then letter of authorization to charge must be on file at clinic)

OWNER(S)/OFFICER(S)/PRINCIPAL(S):

NAME _____ TITLE _____
NAME _____ TITLE _____
NAME _____ TITLE _____

WORKERS COMP. INSURANCE CARRIER - POLICY #: _____
NAME: _____
ADDRESS: _____

IF THIS ACCOUNT IS FOR FISHING VESSELS PLEASE LIST NAMES AND TYPE:

NAME OF VESSEL	TYPE:
_____	_____
_____	_____
_____	_____

BANKING INFORMATION

BANK NAME: _____ BRANCH: _____
ADDRESS: _____
PHONE: _____ CONTACT: _____

"Serving Unalaska, the Aleutian Islands and the Bering Sea"

ILIULIUK FAMILY AND HEALTH SERVICES, INC.

BUSINESS CREDIT APPLICATION (cont'd)

CREDIT REFERENCES:

1) NAME_____ACCT.#_____
PHONE # _____FAX # _____
HIGHEST BALANCE $ _____CURRENT BALANCE $_____
ACCOUNT LIMIT $ _____

2) NAME_____ACCT.#_____
PHONE # _____FAX # _____
HIGHEST BALANCE $ _____CURRENT BALANCE $_____
ACCOUNT LIMIT $ _____

3) NAME_____ACCT.#_____
PHONE # _____FAX # _____
HIGHEST BALANCE $ _____CURRENT BALANCE $_____
ACCOUNT LIMIT $ _____

I, _____ CERTIFY THAT ALL OF THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I REALIZE THAT **FALSE OR INCORRECT INFORMATION**, OR THE **OMISSION OF ANY REQUESTED INFORMATION** MAY RESULT IN DENIAL OF CREDIT.

THE UNDERSIGNED REQUEST EXTENSION OF CREDIT AND AGREES TO RENDER PAYMENT IN FULL WITHIN **30 DAYS OF DATE OF SERVICE**. FAILURE TO RENDER PAYMENT IN FULL ACCORDING TO THESE TERMS MAY RESULT IN REVOCATION OF CREDIT PRIVILEGES.

Iliuliuk Family and Health Services, Inc. (IFHS), is hereby authorized to access credit information relating to above Customer from any source in order to evaluate the creditworthiness of Customer, and shall have the right to access such information upon application, as well as all times thereafter. Customer hereby directs all entities on the face of this document, or which otherwise possess information relating to the creditworthiness of Customer, to fully release such information to IFHS. To the extent that any entity requires authorization in writing from Customer for releases of such information, a photocopy of this document shall be deemed sufficient.

SIGNED: _____DATE:_____

PRINT NAME: _____TITLE:_____