Client Account Application

For LPs and Commercial MM Producers

www.Avanti Rx.com
Ph. 416 – 548 – 5998
Fax 416 – 548 - 5990

Client Identification Number: (For office use only)	**CIN - -**

CLIENT/CUSTOMER CONTACT	
Company:	
Mailing Address:	
Main Phone No.:	
Main Fax No.:	

BILLING CONTACT	
Contact Name:	
Phone No.:	
Fax No.:	
E-mail:	
Address: (if different)	

BILLING INFORMATION	
Contact Name:	
Phone No.:	
Fax No.:	
E-mail:	
Address: (if different)	

BUSINESS & FINANCIAL INFORMATION

Type of Ownership: ☐ Corporation ☐ Partnership ☐ Non-profit ☐ Government Agency ☐ Licensed Marihuana Producer

Type of Business: ________________ Duration in Business: _____ Years Annual Sales: $________ CAD

REFERENCE & CREADIT INFORMATION

References	Organization Name	Contact Name	Affiliation	Phone No.	Fax No.	Mobile	E-mail
Bank							
Reference 1							
Reference 2							
Reference 3							

AUTHORIZATION

Please read the information on this form carefully and completely.

I/We have provided information about my/our credit application. I/We authorize the ARA – Avanti Rx Analytics Inc. to conduct a reference check with those individuals listed above. I/We understand that reference information may include, but not be limited to, verbal and written inquiries or information about my/our credit history and business ratings.

Name: ____________________ Signature: ________________ Date: ________________

Name: ____________________ Signature: ________________ Date: ________________

Name: ____________________ Signature: ________________ Date: ________________

CREDIT CHECK AUTHORIZATION

The above trade name is adopted by the Undersigned, who is/are jointly responsible for all goods or services ordered in this name. Upon approval of credit, I/We agree to honor the ARA – Avanti Rx Analytics Inc. credit terms of net 30 days in Canadian or US Dollar funds. If payment is not made in accordance of terms, I/We understand that a service charge of 1.8 % per month on past due accounts will accrue.

I/We hereby grant to ARA – Avanti Rx Analytics Inc. authorize release ratings and payment record information as required to ARA – Avanti Rx Analytics Inc. to obtain a standard factual data credit report through a credit reporting agency chosen by ARA – Avanti Rx Analytics Inc.

My/our signature/s below authorize the release to the credit reporting agency a copy of my/our credit application. I/We understand that all information released to ARA – Avanti Rx Analytics Inc. will be held in strict confidence.

Legal Company Name: ____________________________ Business Registration No.: ____________________

Company Address: ____________________________ Phone: ____________ Fax: ________________

____

Authorized Person's Name: ____________________ Title: ____________ Signature: ______________ Date: ____________

Authorized Person's Name: ____________________ Title: ____________ Signature: ______________ Date: ____________

ARA – Avanti Rx Analytics Inc.,
135 Devon Road, Unit 11, Brampton, Ontario, Canada L6T 5A4