PHONE: (815) 609-7600 FAX: (815) 888-4095

OR SCAN/EMAIL ALL DOCUMENTS TO INFO@COLOSSALHEALTH.COM

Account Registration Checklist

FAX/EMAIL FOLLOWING DOCUMENTS:

____ ***COPY OF STATE PHARMACY LICENSE***

____ ***COPY OF DEA LICENSE***

____ ***COPY OF PHARMACIST IN CHARGE LICENSE***

____ ***COPY OF CERTIFICATE OF BUSINESS REGISTRATION***

____ ***COPY OF MOST RECENT INVOICE FROM PRIMARY***

____ ***TAX EXEMPT CERTIFICATE/ EIN NUMBER***

____ ***CHECK(VOIDED) FOR EFT PAYMENT REGISTRATION***

____ ***APPLICATION FILLED OUT IN FULL(CREDIT APPLICATION, CREDIT AGREEMENT, & EFT AUTHORIZATION AGREEMENT)***

*****If you have questions in regards to any section within the application please contact your Account Manager at (815) 609-7600 or email: info@colossalhealth.com***

COLOSSAL HEALTH, INC. – Credit Application

Date (MM/DD/YYYY)

For review and quick approval send via fax **1-815-888-4095**
or mail to: COLOSSAL HEALTH, INC. **23860 W. INDUSTRIAL DR. N., PLAINFIELD, IL 60585** PHONE: (815) 609-7600

General Information

Pharmacy / institution name		DBA (If different from pharmacy name)	
Street Address	City	State	Zip Code
Telephone	Fax		Hours of Operation
Pharmacist Name		Cell phone	
President / owner's name		Cell phone	
DEA license number		Expiration date (MM/DD/YYYY)	Issue date (MM/DD/YYYY)
State License Number		Expiration date (MM/DD/YYYY)	Issue date (MM/DD/YYYY)
TAX ID #:		ORGANIZATION ID # (Issued by the State of Formation):	

****MUST PROVIDE COPY OF DEA AND STATE REGISTRATION WITH APPLICATION****

Credit References

PLEASE PROVIDE ALL THREE CREDIT REFERENCES

1.	Institution Name	Telephone	Fax
	Address	City	ST/Zip
2.	Name	Telephone	Fax
	Address	City	ST/Zip
3.	Name	Telephone	Fax
	Address	City	ST/Zip

Business Information (Please circle one)

Are you a member of a Group Purchasing Organization? **YES** **NO**	BUSINESS FORM: **SOLE PROPRIETOR** **CORP** **PARTNERSHIP** **LLC**	Will goods purchased be resold? **YES** **NO** If Yes in which form? **AS IS** **REPACK** **Intl.**
Are there any judgments over $50,000 filed against applicant? **YES** **NO** Are you an Internet Pharmacy **YES** **NO**	Has applicant ever filed for bankruptcy? **YES** **NO** If yes please attach explanation.	Drug License Type: **PHCY** **CHAIN** **CLOSED DOOR** **CLINIC**

Bank References

Bank Name		Telephone		Fax
Address	City		State	Zip
Checking Account Number		Savings Account Number		

Shipping Confirmation	Account Manager
Email Address (for shipping confirmation purposes)	Colossal Health Representative

Credit Agreement/Personal Guarantee

By signing this agreement, the BUYER understood that:

PRICES: The prices are subject to change without notice. The updated price list will be mailed or faxed to the BUYER within 15 days from the date of change.

TERMS: All payments will be drawn via ACH by COLOSSAL HEALTH INC. 23860 W. Industrial Drive N., Plainfield, IL 60585. All payments will be drawn per the Payment Terms Schedule. There will be a $35.00 charge for any NSF ACH payment. A second attempt will be made in two days; if the ACH payment gets rejected for the second time, then there will another charge of $35.00, for the reason of NSF, then the BUYER will have to send the payment via Cashier's Check.

COST OF GOODS: Please see Pricing Grid for COG.

SERVICE CHARGE: The BUYER understood and agreed that any invoice remaining unpaid beyond the terms specified shall be subject to a monthly service charge of one and a half percent (1.5%) for each thirty (30) day period (annual percentage rate of 18%) - that such invoice shall remain unpaid.

LATE FEES & CHARGES: To the extent not prohibited by law, COLOSSAL HEALTH INC., will charge and the BUYER agrees to pay the above stated service charge plus a late fee of $25.00 if the BUYER fails to make required payment within 10 days after the payment due date.

DAMAGE & LOSS CLAIM: The BUYER agrees to notify COLOSSAL of damages in shipment within 48 hours; to state any loss and visible damages; to claim all loss and damage of the shipment to the delivery carrier.

RETURN MATERIAL: No material may be returned without proper authorization from COLOSSAL. All returned material will be subject to a 20% restocking charge unless the material has defect. The BUYER will be responsible for return freight and other charges.

DEFAULT-COLLECTION COSTS: If all or any part of the indebtedness incurred by reason of extension of credit shall be collected by or through an attorney at law or any outside sources, COLOSSAL may charge the BUYER reasonable attorney's fee and Court costs as permitted by law and as actually incurred by the BUYER in addition to the principal amount of the indebtedness, accrued finance and collection costs.

SUSPENSION OF CREDIT: If the BUYER'S account balance is delinquent or in default, at COLOSSAL'S discretion, COLOSSAL may not authorize a shipment for the BUYER'S purchase order.

CHANGE OF TERMS: COLOSSAL may change any term or part of this Agreement by sending the BUYER a written notice before the change is to become effective. COLOSSAL HEALTH INC. may apply any such change to the outstanding balance of the BUYER'S account on the effective date of the change and to new orders placed thereafter. If the BUYER does not agree to the change, the BUYER must notify the COLOSSAL in writing within 7 days after the effective date of the change at the address provided in the notice of change, in which case the BUYER'S account will be closed and the BUYER must pay COLOSSAL the balance under the existing terms of the unchanged invoice terms.

CHANGE OF ADDRESS: If the BUYER changes address and telephone and fax numbers, the BUYER must notify COLOSSAL HEALTH INC. of the new address and telephone and fax numbers within 15 days.

GOVERNING LAW: This Account Agreement shall be governed by the laws of ILLINOIS.

PERSONAL GUARANTEE - (MUST SIGN): In consideration of credit being extended by COLOSSAL HEALTH INC. to the above named buyer for merchandise to be purchased, whether applicant be an individual or individuals, a proprietorship, a partnership, a corporation, or other entity, the undersigned guarantor or guarantors each hereby contract and guarantee to COLOSSAL HEALTH INC., the faithful payment, when due, of all accounts of said applicant for purchases made within five years next after the date of this agreement. The undersigned guarantor or guarantors each hereby expressly waive all notice of acceptance of this guarantee, notice of extension of credit to applicant, presentment, and demand for payment on applicant, protest and notice to undersigned guarantor or guarantors of dishonor or default by applicant or with respect to any security held by COLOSSAL HEALTH INC., extension of time of payment to applicant, acceptance of partial payment or partial compromise, all other notices to which the undersigned guarantor or guarantors might otherwise be entitled and demand for payment under this guarantee. Any revocation of this guarantee shall be in writing and delivered to COLOSSAL HEALTH INC.

NOTICE TO APPLICANT: DO NOT SIGN THIS ACCOUNT AGREEMENT BEFORE YOU READ IT. The Buyer agrees to be bound by the terms and conditions of this Agreement for extended credit. The APPLICANT authorizes COLOSSAL HEALTH INC. agents to investigate the Buyer's credit and financial records, including the balances of any checking and saving accounts. The Buyer certifies that the information contained in the application is true and correct as of this date and the Buyer agrees that any person who signs below on the Buyer's behalf is authorized and enter into this Account Agreement.

>BUYER UNDERSTANDS AND AGREES THAT THE CREDIT LINE WILL BE REDUCED AND THE ORDERS WILL BE HELD IF BUYER'S ACCOUNT IS 10 DAYS OR OLDER PASTDUE.

>BUYER UNDERSTANDS THAT THE CREDIT TERM WILL NOT BE APPROVED UNLESS CREDIT APPLICATION IS COMPLETED AND SIGNED.

____ ____________________

SIGNATURE – (AGREE TO BE PERSONAL GUARANTOR) DATE

_____________________________________ Social Security Number ____________________

NAME (PRESIDENT OR MAJOR OWNER) PLEASE PRINT REQUIRED

This Credit Application covers the following branches or subsidiaries of the company.

Business Name ____________________________ Phone # ____________ Fax # ____________

Address ________________________________ City _________ State _______ Zip Code _______

Business Name ____________________________ Phone # ____________ Fax # ____________

Address ________________________________ City _________ State _______ Zip Code _______

Please attach a list of additional business names if there are more.

THE ORIGINAL COPY OF THIS AGREEMENT MUST BE MAILED TO COLOSSAL HEALTH INC.

EFT AUTHORIZATION APPLICATION

For Pre-Arranged Payments (ACH Debits)

CHI Account # ______________________________

Company Name ______________________________

Phone Number ____________________ Fax ____________________

Street Address ______________________________

City____________________State__________Zip________

Bank Name ______________________________

City____________________State__________Zip________

Bank Account #____________________Bank Transit Routing #________________(9 digits)

I hereby authorize Colossal Health Inc. to initiate debit entries against my bank account indicated above and the financial institution named above to debit the same to such account

It is understood that this agreement may be terminated by one of me (us) at any time by written notification to Colossal Health Inc. Any such notification to Colossal Health Inc. shall be effective only with respect to entries initiated by Colossal Health after receipt of notification and a reasonable opportunity to act on it. Any such notification to Bank shall be effective only with respect to entries debited to my (our) account by Bank after receipt of such notification and a reasonable time to act on it.

Authorized Signature	Date	Authorized Signature	Date
(Print) Name and Title		(Print) Name and Title	

Please attach to the completed application a VOID blank check in the space provided below or on a separate sheet.

When completed, please fax documents to Colossal Health @ **(815) 888-4095**