11381 Decimal Drive
Louisville, KY 40299
Phone 877-559-5963
Fax 877-683-2065

KY Meds Inc.

Customer Agreement

** Copy of license(s) must be faxed or emailed **

Company Name (trade name if different) _____

Address (Billing) _____ City_____ State_____ Zip_____

Address (Ship To)_____City_____ State_____Zip_____

Phone_____Fax_____Email_____

State Lic#_____ Exp_____ State_____ (Please attach copy of license)

Type of Pharmacy: Retail/LTC/Specialty Center/Other_____ # of locations_____

Principal Officers and/or Partners

1. Name_____ Title_____Tel_____
2. Name_____ Title_____Tel_____

Purchasing Agent_____A/P Contact_____

Credit References

Primary Wholesaler_____

Secondary Generic Supplier_____

Bank Name_____ Acct Number_____

Address_____ City_____ State_____ Zip_____ Tell_____

We authorize you to check our company credit rating and verify the information provided in this credit application.

By signing, using, or requesting issuance of credit by KY Meds Inc, we agree to the following:

1. This is an unconditional personal guarantee for all credit extended by KY Meds Inc or its subsidiaries in connection with the purchase of any and all goods. Further, the guarantor agrees to subject their company to the jurisdiction and venue of the Kentucky courts.
2. We understand our terms are Net 20 subject to credit approval and agree to pay at the place designated on the invoice all drafts and obligations, evidence of credit, and all extensions of credit, and all finance charges when imposed, either
   a. In full upon due date, or
   b. If not paid upon due date, a 1.5% monthly finance charge will be assessed
   c. On default or failure to pay as agreed, you will pay to KY Meds Inc or its subsidiaries collection costs, the maximum monthly finance charge permitted, and reasonable attorney's fees.
   d. Customer agrees to pay a 20% restocking fee on all AUTHORIZED returns. No credit will be given to UNAUTHORIZED returns.
3. We hereby grant permission to KY Meds Inc. and its subsidiaries to send advertising and promotional materials to the email(s) and fax number(s) listed above. This operates as consent under the 47 U.S.C. § 227 of the Telephone Consumer Protection Act.
4. This agreement is binding on your representatives, successors, and assigns.

_____ _____

Signature of Principal/Guarantor Date

_____ _____

Printed Name Title

Submit Customer Agreement and Recurring Payment Authorization Form to:

Email: Sales@kymeds.com or Fax: 877-683-2065 Rep _____