BLACK LAB OPTICAL

MEMBER APPLICATION FOR AN OPTICAL LAB ACCOUNT

Doctor:			
Company name:			
Phone:	Fax:	E-mail:	
Registered Practice address:			
City:		State:	ZIP Code:
Sole proprietorship:	Partnership:	Corporation:	Other:

BUSINESS AND CREDIT CARD INFORMATION

Credit Card Name First:	Last:		
Company Name			
Address:	Suite:	City/State:	ZIP Code:
Telephone:	Please provide Email for Receipt.	E-mail:	
C.C. Expiration Date:		C.C. CVV#	
Bank ACH:	Account #:	Routing#	
Savings			
Checking			

BUSINESS/TRADE REFERENCES

Company name:			
Address:			
City:		State:	ZIP Code:
Phone:	Fax:	E-mail:	
Type of account:			
Company name:			
Address:			
City:		State:	ZIP Code:
Phone:	Fax:	E-mail:	
Type of account:			

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 BLACK LAB OPTICAL to make inquiries into the banking and business/trade references that you have supplied.

SIGNATURES

Title: Date:	Title: Date: