AESCULAP

(Credit application may be utilized for Aesculap Implant Systems, LLC)
(Revised 7/15/2024 - **all other forms are obsolete and will not be accepted**)

Accounts Receivable
824 12th Ave.
Bethlehem, PA, 18018

Credit Information

FAX: 610-849-1331 or email to:
CS_CustFileMaint@bbraunusa.com

PLEASE complete all sections of the credit information sheet. Should a section not apply, please indicate "Not Applicable". **Failure to complete the form in its entirety will result in the delay of the requested account being established and with credit being denied.**

Note: Please understand that all FEIN information will/must be verifiable. If the FEIN is not in the reference databases, it shall be applicant's responsibility to contact the IRS at 1-800-829-0115 and request appropriate documentation to validate the FEIN.

Customer/Facility Name: _____
(Shipping)

Facility Telephone #: _____ Facility Fax #: _____

Facility Address: _____ Ste: _____

City: _____ State: _____ Zip: _____

FEIN: _____ DUNS # _____

Customer/Facility Name: _____
(Billing)

Billing Address: _____ Ste: _____

City: _____ State: _____ Zip: _____

FEIN: _____ DUNS #: _____

Customer/Facility Name: _____
(Payer - financially responsible entity)

Payer's Address: _____ Ste: _____

City: _____ State: _____ Zip: _____

FEIN: _____ DUNS #: _____

Type of Business:

☐ Veterinary ☐ University/College ☐ Lab/Research ☐ Distributor *
☐ Dental Office ☐ Hospital ☐ Govt Facility ☐ Manufacturer**
☐ Doctor Ofc/Clinic ☐ Surgery Center ☐ Other Please Explain _____ ***

* Distributor - Type of facilities your company distributes to: _____
If Distributor, would your company provide sales tracings for the purpose of charge-backs and/or rebates?
☐ YES ☐ NO

** Manufacturer - Type of product: _____

*** Exporter - Identify all countries: _____

Intended use of Aesculap Product(s): ☐ Resell ☐ Use within your company as identified above

Company Web Site Address: _____

Group Purchasing Organization: _____

Pharma License: _____ **St:** _____ **Medical Director's License:** _____ **St:** _____

Expiry Date: _____ **Expiry Date:** _____

WE BELIEVE THAT OUR FIRM IS AND WILL CONTINUE TO BE FINANCIALLY ABLE TO MEET ANY AND ALL COMMITMENTS WE HAVE MADE OR MAY MAKE AND WE WILL PAY YOUR INVOICES ACCORDING TO YOUR TERMS. WE UNDERSTAND THAT A SERVICE CHARGE WILL BE ASSESSED ON PAST DUE INVOICES AT THE HIGHEST RATE ALLOWED BY LAW, AND WE AGREE TO PAY SUCH SERVICE CHARGES WHEN BILLED. ALL PAYMENTS WILL BE MADE TO AESCULAP, PO BOX 780426, PHILADELPHIA, PA 19178-0426, WHICH IS THE AGREED SITE OF ANY COLLECTION ACTION THAT MAY BE BROUGHT ON THIS ACCOUNT. IN THE EVENT OF SUCH ACTION WE AGREE TO PAY ALL COSTS AND REASONABLE ATTORNEY FEES. IF WE OBJECT TO ANY INVOICE CHARGE OR THE QUALITY OF ANY PRODUCT DELIVERED TO US BY AESCULAP WE MUST NOTIFY AESCULAP IN WRITING WITHIN TEN (10) DAYS OF THE DATE OF INVOICE, STATEMENT OF ACCOUNT, OR DELIVERY AT ADDRESS SPECIFIED ABOVE. WE (I) THE UNDERSIGNED, AUTHORIZE AESCULAP TO VERIFY OUR CREDIT STATUS WITH THE PROVIDED CREDIT TRADE REFERENCES. THE PURCHASE AND SALE OF THE PRODUCTS REFERENCED HEREIN SHALL BE GOVERNED BY AESCULAP'S TERMS AND CONDITIONS, WHICH SUPERSEDE THE TERMS AND CONDITIONS OF ANY PURCHASE ORDER OR OTHER DOCUMENTATION USED BY CUSTOMER. WE UNDERSTAND AND AGREE THAT ANY CHANGE IN TERMS MUST BE AUTHORIZED IN ADVANCE BY AESCULAP FINANCE MANAGEMENT.

Name of Corporation (Payer): _____ Date: _____

Signature: _____ Print: _____

Title: _____

AESCULAP

(Credit application may be utilized for Aesculap Implant Systems, LLC)

Accounts Receivable
824 12th Avenue
Bethlehem, PA 18018

Credit Information
(continued)

FAX: 610-849-1331 or email to:
CS_CustFileMaint@bbraunusa.com

PLEASE NOTE: Should customer claim tax exemption, the Tax Exemption Certificate for any/all jusridiction(s) Aesculap product will be delivered to **MUST** be provided at the time that the Credit Information Form is submitted. Requests/Orders cannot be processed without a copy of your Tax Exemption Certificate. Additionally, Distributors & Exporters must attach a copy of their valid Resale Certificate for each ship to State.

Customer/Facility Name: _____

Tax Exemption Status: ☐ Exempt ☐ Non-Exempt State(s) Exempt: _____

Tax Exemption Certificate: ☐ Attached ☐ Not Attached ☐ Not Applicable - Non Exempt

Trade Reference(s) *(Excluding Utility Companies):*

Company Name: _____
Phone #: _____
Account #: _____
Contact: _____

Company Name: _____
Phone #: _____
Account #: _____
Contact: _____

Bank Reference(s)

Bank Name: _____
Phone #: _____
Account #: _____
Contact: _____

Your Internal Company Contact Information

Accounts Payable:
Name: _____
Telephone #: _____
Email: _____

Purchasing:
Name: _____
Telephone #: _____
Email: _____

Freight (Third Party Freight Vendor, if applicable, ie...OptiFreight, Triose, FDSI, etc.)

Freight Vendor: _____
Account Number: _____
(specify FedEx or UPS)

Please Attach "Shipping Routing Guide"

Please complete as applicable

Purchasing Contact: _____
Telephone: _____
GLN: _____
DEA #: _____

Your organization must clearly define the method in which you shall receive your invoices below:

☐ Email Email address provided must be generic in nature to a company server such as your AP general email address, not a specific person

☐ EDI Provide your EDI contact email and telephone number and we will provide same to our EDI team. Additionally provide your EDI partner

---

Aesculap Remittance Information

IF PAYING BY CHECK, PLEASE REMIT PAYMENTS TO:
AESCULAP INC.
PO BOX 780426
PHILADELPHIA, PA 19178-0426

AESCULAP ACCOUNTS RECEIVABLE

EAST	1-877-897-0132	X4252
CENTRAL	1-877-897-0132	X4395
WEST	1-877-897-0132	X4376

Aesculap Implant Remittance Information

IF PAYING BY CHECK, PLEASE REMIT PAYMENTS TO:
AESCULAP IMPLANT SYSTEMS, LLC
PO BOX 780391
PHILADELPHIA, PA 19178-0391

Our preferred method of payment is ACH, please contact our Cash Applications Supervisor Lisa Bahnck @ lisa.bahnck@bbraunusa.com if you are interested in setting up your organization for ACH