Dealer Application

Juzo® Since 1912

Please fill out both pages COMPLETELY and fax them with your first order. Please PRINT or TYPE.

Billing Information

Business Name _____ Tax ID # _____

Address _____

_____

City _____ State _____ Zip _____

Phone _____ Fax _____

Shipping Information

Complete if different than Billing Information

Business Name _____

Address _____

_____

City _____ State _____ Zip _____

Phone _____ Fax _____

Contact Information

Owner/ President _____ Ext _____ Email _____

Purchasing _____ Ext _____ Email _____

Fitter _____ Ext _____ Email _____

Accounting _____ Ext _____ Email _____

Credit References

(Required to process)

Company _____ Company _____

Address _____ Address _____

City/State/ Zip _____ City/State/ Zip _____

Phone _____ Phone _____

Account Number _____ Account Number _____

Bank References

(Required to process)

Company _____

Address _____

City/State/ Zip _____

Phone _____

Account Number _____

General Information

How long have you been in business? _____

How many employees? _____

Do you have branches? YES / NO

if so, how many? _____

I certify that the information provided on this application to be complete and correct to the best of my knowledge. I also agree to the terms listed on the second page of this application.

_____ and / or _____

Owner Signature Authorized Signature

Dealer Application

Juzo® Since 1912

Business Name _____

City _____ State _____

How would you classify your facility?

- ○ Home Health Care / Surgical Supply / DME
- ○ Pharmacy with Home Health Care
- ○ Pharmacy without Home Health Care
- ○ Federal Government Entity
- ○ Podiatrist
- ○ Professional Orthotics and Prosthetics
- ○ Women's Boutique
- ○ Other, please specify _____

What type of products do you carry? (Please specify which brands you currently use.)

- ○ Compression Stockings _____
- ○ Arm Sleeves / Hand Portions _____
- ○ OTC Support Stockings _____
- ○ Stump Shrinkers / Suspension Sleeves _____
- ○ Knee Braces / Supports _____
- ○ Ankle Braces / Support _____
- ○ Orthopedic Shoes / Footwear _____

About your compression garment business.....

1) Do you have a private fitting room to measure patients? YES / NO
2) Do you have a fitter trained in measuring for compression garments? YES / NO
3) Have you met your local JUZO representative? YES / NO
4) Are you presently getting prescriptions for JUZO products YES / NO
5) If you answered no to questions 3 and 4, how did you hear about JUZO? _____
6) Approximately how many compression garment fittings do you do per week? _____

Juzo sends invoices and statments via email. Please provide email address(es) if you prefer electronic invoices or statements

Email _____ Email _____

○ Please send invoices via regular mail

Do you have an e-commerce site? YES / NO Web address _____

Do you promote compression products on your website? YES / NO Web address _____

Who will be the primary contact for the following?

Product / Pricing Information and Updates _____ Email _____

Terms

Account set-up: ***Your application will be processed with your first order. Please fax this application and your first order to 1 800 645-2519. Should you have any questions, you can contact us at 1 800 222-4999.***

Shipping: Free UPS Ground shipping on orders exceeding $500, shipped from Cuyahoga Falls, Ohio.

FOR OFFICE USE ONLY

Account Number _____ Customer Group _____ Billing Representative _____

DEALERAPP-0613

Find product images, order forms, marketing materials, size charts and more at
www.juzousa.com/dealer or www.juzo.ca/dealer