Paradigm Medical Inc.

CUSTOMER APPLICATION

PLEASE ALLOW 3-5 BUSINESS DAYS FOR PROCESSING

Name: Business and Billing Address

Name: _____

Address: _____

_____

Business Number (BN): _____

Phone: _____Fax: _____Email: _____

How did you hear about us? _____

Permission to email: ☐ (Please check box) Signature: _____

Shipping Address (*if different from above*)

Address: _____

_____

Type of Business: _____ Date Established: _____

Owner's Name: _____

Trade References:

Name: _____Fax: _____ Email: _____

Name: _____ Fax: _____ Email: _____

Credit Card Information:

Credit Card# _____Exp. Date: _____ CVS: _____

Name as printed on card: _____ Signature: _____

Permission to charge credit card when invoiced: ☐ (Please check box)

Please return by fax or email to sandra@paradigmmed.com or customerservice@paradigmmed.com
or mail to: 19 Waterman Ave., Unit 6, Toronto ON M4B 1Y2 Toll Free:1-800-931-2739
Fax: 416-362-0729; Tel: 416-362-0844; www.paradigmmed.com