12 West 27 Street #300
New York, NY 10001
Tel: 212.473.7010
Fax: 212.473.7095
www.perfectoptical.com

For Office Use Only

Credit Limit	Date Opened	Acct Rep	Acct #
Payment Method/Info:			

The undersigned hereby request Perfect Optical Corporation and Perfect Optical Lab Corporation to extend credit to:

Company _____ Trade Name (DBA) _____

Address _____ City _____ State _____ Zip _____

Tel _____ Fax _____ E-mail _____

Contact Name _____ Position _____

Business Type:
- ☐ Individual/Sole Owner
- ☐ Corporation
- ☐ Partnership

Date Opened _____

Tax ID _____

Bank Reference

Bank Name _____ Acct Number _____

Contact _____ Tel _____

Trade Reference

1. Company _____ Acct Number _____ Contact _____ Tel _____

2. Company _____ Acct Number _____ Contact _____ Tel _____

3. Company _____ Acct Number _____ Contact _____ Tel _____

4. Company _____ Acct Number _____ Contact _____ Tel _____

The undersigned declares that they completed the application fully and truthfully. With their signature the undersigned gives the authority for financial, trade, and credit agencies to release information pertaining to their credit.

The undersigned individuals purchasing merchandise from Perfect Optical Corporation and/or Perfect Optical Lab Corporation do each personally guarantee payment to Perfect Optical Corporation and/or Perfect Optical Lab Corporation without prior notice or demand of all amounts heretofore or hereafter owed to Perfect Optical Corporation and/or Perfect Optical Lab Corporation.

It is understood and agreed that should Perfect Optical Corporation and/or Perfect Optical Lab Corporation deem it necessary to place the purchaser's account with an attorney or collection agency the purchaser will pay all reasonable attorney's fees and costs related and incurred in addition to the amount owed.

1. Signature_____ Name _____ Social Security Number _____

Home Address _____ City _____ State _____ Zip _____

2. Signature_____ Name _____ Social Security Number _____

Home Address _____ City _____ State _____ Zip _____

PERFECTOPTICAL

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Acct #

Payment Authorization

The undersigned hereby authorizes Perfect Optical Corporation and/or Perfect Optical Lab Corporation to charge:

☐ One Time Only in the amount of $ _____.

☐ Weekly, every _____, in the full amount of the previous week's purchases.

☐ Monthly, on the _____ of every month, in the full amount of the previous month's purchases.

☐ Other, Please Specify _____

Account Name _____Account Number _____

Card Type _____ Card Number _____ CSV Code _____

Name on Card _____ Expiration Date _____

Card Address _____City _____State _____ Zip _____

Authorized Signature _____ Date _____

Name (Please Print) _____