Email: sales@posturemedic.com

POSTURE MEDIC DISTRIBUTOR APPLICATION

Thank you for your interest in becoming a distributor for Posture Medic.

COMPANY PROFILE

Company Name:			**Country:**
Year Company Started:	**Corporation ❑**	**Partnership ❑**	**Government ❑**	**Sole Proprietorship ❑**
Telephone:	**Fax:**		**Website:**
Years in Business:	**Number of Employees:**		**Number of Sales People:**
Projected Revenue for this Year:		**Last Year's Revenue:**	

Type of Business: ❑ Distributor ❑ Manufacturer ❑ Retail ❑ Healthcare ❑ Online

Does the company have Distributors?	**❑ Yes**	**❑ No**	**If so how many?**
Does the company supply Retail Stores?	**❑ Yes**	**❑ No**	**If so how many?**
Does the company supply Clinics/Healthcare?	**❑ Yes**	**❑ No**	**If so how many?**
Does the company exhibit at Consumer Tradeshows?	**❑ Yes**	**❑ No**	**If so how many?**

Top 5 Current Products:

1. _____ 2. _____ 3. _____ 4. _____ 5. _____

TRADE REFERENCES

Company Name:	**Contact:**	**Annual Purchase:**
Company Name:	**Contact:**	**Annual Purchase:**
Company Name:	**Contact:**	**Annual Purchase:**

COMPANY CONTACT INFORMATION

Sales:	**Phone:**	**Email:**
Purchasing:	**Phone:**	**Email:**
Shipping/Logistics:	**Phone:**	**Email:**
Marketing/Graphics:	**Phone:**	**Email:**

APPLICANT INFORMATION

Name of Applicant:	**Phone:**
Email of Applicant:	**Date:**