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To be Completed by All Prospective Customers			
Form Completed By:	Telephone:	Email:	Date:
Legal Company Name:	GLN (Global Location Number):	VAT Number:	Country:
Shipping Address:		Billing Address:	
City:		City:	
State (optional):	Postal/Zip Code:	State (optional):	Postal/Zip Code:
Country:		Country:	
Purchasing Contact:	Title:	Email:	Telephone:
Accounts Payable Contact:	Title:	Email:	Telephone:
Business Contact:	Title:	Email:	Telephone:
Product Categories and Estimated Annual Sales:		Competitive Products:	
For Internal Use ONLY			
To be completed by Export			
Primary Warehouse: <input type="checkbox"/> Key Surgical US <input type="checkbox"/> Key Surgical UK <input type="checkbox"/> Key Surgical DE			
Agreement Type: <input type="checkbox"/> Exclusive <input type="checkbox"/> Standard <input type="checkbox"/> EU Short Form		Distributor Agreement Received: <input type="checkbox"/> Yes <input type="checkbox"/> N/A    Date: _____	
Customer Account #:	Credit Terms:	Salesperson ID:	Customer Class:
Incoterm:		Territory ID:	
Special Requirements:			
Entered By:		Date Entered:	
To be completed by Regulatory			
Product Registration Received: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A    Date: _____			
Regulatory Approval:			Date:
Export Final Approval:			Date: