

DISTRIBUTOR APPLICATION



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2319 NE Glisan Street • Portland, OR 97232

Owner Name			
Company Name			
Company Address, City, ST Zip			
Parent Company (if different)			
Telephone		Fax	
Email			
Website			
Est. Monthly Purchases			

BANK REFERENCES - *Required Fields

*Bank Name		Contact Name	
*Bank Address, City, ST Zip		Contact Phone	
*Bank Telephone		Contact Email	
*Account Number		Federal ID #	

TRADE REFERENCES – minimum of 3

Company Name		Company Name	
Contact Name		Contact Name	
Street Address		Street Address	
City, State, Zip		City, State, Zip	
Telephone		Telephone	
Email		Email	
Account No.		Account No.	

Company Name		Company Name	
Contact Name		Contact Name	
Street Address		Street Address	
City, State, Zip		City, State, Zip	
Telephone		Telephone	
Email		Email	
Account No.		Account No.	

I certify that the above information is true. The above references, including the bank, are authorized to release any and all information necessary to Dermal Source, for the purposes of establishing business validity. **I further certify to Dermal Source that I will only sell anesthetic products to licensed professional businesses and not to end users.**

Print Name

Signature

Date