

CUSTOMER PROFILE

American Psychiatric Association Publishing
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NAME OF BUSINESS

CORPORATION OR OTHER NAME

STREET ADDRESS

CITY

STATE

ZIP

BILLING ADDRESS

CITY

STATE

ZIP

BUSINESS TELEPHONE

ACCOUNTS PAYABLE TELEPHONE

ACCOUNTS PAYABLE CONTACT

COMPANY EMAIL

COMPANY WEB ADDRESS

BANK NAME AND BRANCH

BANK ACCOUNT NO. BANK CONTACT

BANK TELEPHONE

Name and address of officers, partners, owners, or other responsible parties:

NAME

TITLE

STREET ADDRESS

CITY

STATE

ZIP

NAME

TITLE

STREET ADDRESS

CITY

STATE

ZIP

List three businesses with which you have maintained credit for a minimum of one year:

BUSINESS/ACCOUNT NO

TELEPHONE / FAX

STREET ADDRESS

CITY

STATE

ZIP

BUSINESS/ACCOUNT NO

TELEPHONE / FAX

STREET ADDRESS

CITY

STATE

ZIP

BUSINESS/ACCOUNT NO

TELEPHONE / FAX

STREET ADDRESS

CITY

STATE

ZIP

Read before signing. I/we hereby agree to the terms, net 30 days, unless otherwise stated. In the event of collection, customer pays all costs and attorney fees.

NAME (PLEASE PRINT)

TITLE

SIGNATURE

DATE

General Customer Information

Years in business _____

Incorporation year (if applicable) _____

Federal Tax ID or Social Security Number (attach copy) _____

How often does your organization plan to order with us? *(please choose one)*

- Less than once a year*
- Annually*
- Quarterly*
- Monthly*
- More than once a month*

Approved Credit Line \$ _____

Approval Signature

Date