Health Administration Press,
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DISTRIBUTOR APPLICATION

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Billing Address:		
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Contact Name:	Contact Title:	
Contact E-mail:	Contact Phone:	
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Check one: ☐Individual ☐Sole Proprietorship ☐Partnership ☐Corporation ☐Non-profit		

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City:	State:	ZIP:
How long at current address?		
Bank Reference Name:		
Bank Address:		
City:	State:	ZIP:
Type of account: ☐Savings ☐Checking ☐Other		

BUSINESS/TRADE REFERENCES			
1	Company name:		
	Type of account:	Contact Name:	
	Address:		
	City:	State:	ZIP:
	Phone:	E-mail:	
2	Company name:		
	Type of account:	Contact Name:	
	Address:		
	City:	State:	ZIP:
	Phone:	E-mail:	
3	Company name:		
	Type of account:	Contact Name:	
	Address:		
	City:	State:	ZIP:
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