Facility/Office/Agency Account Authorization

FACILITY INFORMATION

Facility Name: _____ Phone: _____

Address: _____

Representative Name: _____ Title _____

Email: _____ Specific styles or colors required: _____ Yes _____No If yes, indicate style #s/brand below*:

# of offices: _____ # of employees: _____ # of sets per person: _____

If additionrestrictions on style, please provide separate sheet with specific style # requirements. *attach separate page if necessary

Monetary limit _____ ☐ per person ☐ per set Other: _____

Color restriction _____ Is this for: ☐ Ongoing basis ☐ One time purchase

☐ If the office will be sizing employees and placing one single order for the entire office at one time, please indicate here. Otherwise, each individual will select their scrubs and take delivery at time of purchase.

AGREEMENT

AUTHORIZATION: Facility agrees to provide an updated employee authorization list/notification when new employees are added and previous employees vacate positions. LoosEndz Mediscrubs is not responsible for unauthorized store charges if an updated list is not provided by the facility. All store charges are the responsibility of the facility and agree to be paid by the facility in a timely manner as outlined below. Please notify LoosEndz Mediscrubs by email (4YourCNA@gmail.com) before sending new employees for scrubs or services to prevent delays for authorization.

PURPOSE: This is an agreement between a facility/office/agency, hereafter known as "facility" and LoosEndz Mediscrubs Uniforms for the purchase of scrubs, apparel, shoes, supplies, accessories, educational material and/or classes without immediate renumeration, individually or in bulk, to place purchases on account to be paid at a later date by facility.

AGREEMENT TO PAY: The facility agrees to remit payment for all invoices within 15 calendar days of invoice submission. The facility representative signing below states unequivocably that they have the authorization to enter into this agreement on behalf of the facility. In the event that the authorized representative is no longer employed by the facility or is no longer in this position, the facility is still bound to honor this agreement and payment terms.

TERMS: LoosEndz Mediscrubs will invoice the facility monthly for outstanding balances and/or when outstanding balances exceed $500.00. LoosEndz Mediscrubs will submit invoices via (select one):

____ email to the email address on file (or) ____ postal mail to the mailing address on file.

Facility agrees to remit payment within 15 calendar days for all invoiced amounts.

PENALTIES: LoosEndz Mediscrubs will assess a late charge, in accordance with FS61M-1.004 (1)(a-d):

a. 10% of total past due for over 30 days past due
b. 15% of total amount due for over 60 days past due
c. 20% of total amount due for over 90 days past due
d. 25% of total amount due for over 120 days past due

For all accounts in arrears, with outstanding unfulfilled invoices over 15 days after invoicing, all further store credit will be placed on hold and no further merchandise will be extended on credit to the facility until the account is brought current.

DURATION: LoosEndz Mediscrubs reserves the right to withdraw the offer of credit to any facility, person or entity at any time, for any reason, with no prior notice.

LEGAL REMEDY: This contract is enforcable under Florida law. All claims and disputes arising under or relating to this Agreement are to be settled either through arbritration or litigation in the state of Florida, as deemed appropriate by LoosEndz Mediscrubs. Facility agrees to pay for all court costs, arbitration costs and attorney fees for any legal action arising from an attempt to collect this debt.

By signing below, the facility representative states that they have the authorization to enter into a binding contract for payment on behalf of the facility and agree to be held to the terms stated herein. The facility agrees to remit payment within 15 calendar days of receipt of invoice. Facility agrees to notify LoosEndz Mediscrubs of any change in Facility contact, address or accounts receivable.

_____ _____

Facility Contact Signature Date

_____

Printed Name