Facility/Office/Agency Account Authorization

FACILITY INFORMATION

Facility Name: _____ Phone: _____

Address: _____

Representative Name: _____ Title _____

AGREEMENT

AUTHORIZATION: Facility agrees to provide an updated employee authorization list/notification when new employees are added and previous employees vacate positions. 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 Mediscrubs by email (loosendzmediscrubs@gmail.com) before sending new employees for scrubs or services to prevent delays for authorization.**

FACILITY RESPONSIBILITY: All Facilities are responsible for authorizing each employee in writing at least 1 business day **PRIOR TO** sending them to Medi-Scrubs. By signing below, employers acknowledge that all employees that have not been authorized in writing to Medi-Scrubs **at least 1 business day in advance** will not be permitted to charge to their employer's account. There are no exceptions to this rule. Employees that have not been pre-authorized in writing are unable to charge to an employer's account under any circumstances. Medi-scrubs **WILL NOT** call an employer for authorization at the time of purchase.

PURPOSE: This is an agreement between a facility/office/agency, hereafter known as "facility" and 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.

INVOICE PERIOD: The facility requests invoices to be submitted for payment (select one):

_____ with each purchase _____ monthly as aggregate _____ when balance reaches $_____

TERMS: Facility agrees to remit payment within 15 calendar days for all invoiced amounts. 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 or their employees until the account is brought current. Mediscrubs will submit invoices via (select one):

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

PENALTIES: 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

DURATION: 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 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 Mediscrubs of any change in Facility contact, address or accounts receivable.

_____ _____

Facility Contact Signature Date

_____ _____

Printed Name Primary Contact Email

23-8MS1

AUTHORIZATION

Contact Email: _____ Facility Name: _____

# of offices: _____ # of employees: _____ Contact Phone #: _____

☐ 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 and we will bill employer on an ongoing basis.

☐ Check here if this office requires emboidery on purchased uniforms (if yes, please provide .dst file if available)

Embroidery pricing will be added at time of purchase

$10 Logo $12 Name 1 line $15 Name 2 line

STYLE/COLOR LIMITATIONS

Used if the facility limits colors/styles or number of items.

# of sets per person: _____ or

Indicate specific items to be billed to account:

_____

Color restrictions: _____

_____

Specific styles or brands required:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

PURCHASE AMOUNT LIMIT

Used if the facility wishes to establish a monetary limit per employee.

Monetary limit: $ _____

☐ per person ☐ per set

Other: _____

How often are employees authorized to charge on account?

_____ one time purchase

_____ once per year (allowance resets annually)

_____ once per quarter (4 x a year)

_____ unlimited

Notes:

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

Medi-scrubs is not responsible for informing employees of required color/style. All changes to uniform requirements must be relayed to Medi-Scrubs prior to implementation. All returns subject to 15% restocking fee.

_____ _____

Facility Contact Signature Date

_____

Printed Name

Submit this complete form (both pages) to Medi-Scrubs when complete, either in person (2911 Commercial Way Spring Hill, FL) or via email (loosendzmedi-scrubs@gmail.com). Call 352-263-2328 with any questions.