Adriatic Seafood

129 Willow ave., Staten Island, New York 10305

Phone #: **718-447-1965** Fax #: **718-876-8696**

Credit Application

CORP. NAME: ____FID#_________________

ADDRESS: ____

CITY: _____________________________________ STATE: _______ ZIP________________

TRADE NAME: ____FID#________________

ADDRESS: ____

CITY: _____________________________________ STATE: _______ ZIP________________

PHONE # ________________________________ FAX # ______________________________

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PRINCIPAL'S INFORMATION

1) OWNERS NAME: ____

TITLE: _____________________________________ S/S # _________-_____-___________

ADDRESS: ____

2) OWNERS NAME: ____

TITLE: _____________________________________ S/S # _________-_____-___________

ADDRESS:____

****

BANK REFERENCE

BANK NAME: ____

CONTACT: ____

ACCT # ____ [ ] CHECKING [ ] SAVING

PHONE: ______________________________ FAX: ___________________________________

TRADE REFERENCE

1)NAME:____

ADDRESS: ____

PHONE: ______________________________ **FAX**____________________________

2) NAME: ____

ADDRESS: ____

PHONE: ______________________________ **FAX** ___________________________

3) NAME:____

ADDRESS: ____

PHONE: ______________________________ **FAX** ___________________________

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PERSONAL GUARANTEE

I HEREBY GUARANTEE FULL AND COMPLETE PAYMENT FOR ALL OPEN INVOICES. I AGREE TO PAY ALL COSTS AND EXPENSES INCLUDING ATTORNEY'S FEES, (COMPUTED AT 35%) INCURRED IN ATTEMPTING TO COLLECT THE AMOUNT DUE ADRIATIC SFD LLC. BY REASON OF NON-PAYMENT WHEN CLAIM IS TURNED OVER TO ATTORNEY FOR COLLECTION. RETURNS AND DEDUCTIONS WILL NOT BE HONORED IF REPORTED MORE THAN 24 HOURS AFTER RECEIPT OF GOODS.

THE UNDERSIGNED AGREE TO THE TERMS AND RETURN POLICIES STATED ABOVE, AND GRANT PERMISSION TO ANY OF OUR REFERENCES TO PROVIDE ADRIATIC SFD LLC. WITH FINANCIAL INFORMATION CONCERNING OUR COMPANY.

____ ____________________

SIGNATURE **DATE**

PRINT NAME: ____

Account Name: ____

Billing Address: ____

____

Statement mailed to [ ] Billing Address [ ] Restaurant

Check one

Restaurant Address: (if different)

____

____

A/P Contact Name: ____

A/P Phone # ______________________________ X ____________

A/P Fax # ____

A/P E-Mail ____

ALL PAGES MUST BE COMPLETED IN FULL

*** ***

OFFICE USE ONLY

[ ] NOT APPROVED [ ] APPROVED ___________LIMIT ____________ TERMS