ΓΟΣΕΙΔΩΝ

CUSTOMER PROFILE

CUSTOMER

NAME:______________________________PHONE:__________

STREET:______________________________FAX:______________

ADDRESS:____

CITY,ST,ZIP: ____________________CORPORATION____PARTNERSHIP__SOLE PROPRIETOR__

OWNERS/PARTNERS: ______________________________

TYPE OF FIRM: WHOLESALE______RETAIL___MANUF__TRADER__

***FED EIN NO.:**_______________SOC SEC NO.:_______________

DATE ESTABLISHED:__________NUMBER OF EMPLOYEES:______

SALES CONTACT:______________PAYABLES CONTACT:______________

BANK

NAME & BRANCH:______________________________PHONE:______

ADDRESS:____

CONTACT:____________________TITLE:____________________

CREDIT REFERENCES

NAME:____________________________________PHONE:______

ADDRESS:____

ASSOCIATION:______________________________NO. YEARS:________

NAME:____________________________________PHONE:______

ADDRESS:____

ASSOCIATION:______________________________NO. YEARS:________

SIGNED:______________TITLE:________________DATE:______

1. All invoices are to be paid upon receipt
2. Claims arising from invoices must be made within 7 working days.
3. By submitting this application, you authorize Poseidon Forwarding Company to make inquiries into the banking and business/trade references that you have supplied.