CREDIT APPLICATION - Excalibur Intl

REMIT TO:
E-mail: accounts@excaliburintl.com
Fax: 310-568-1604

Credit Limit Requested:

Name of Business:				Tax ID Number:
Last Name:		First Name:		Title:
Physical Address:				D-U-N-S Number:
City:	State:	Zip:	Phone:	Fax:

COMPANY INFORMATION

Type of Business:		Years in Business:	
Legal form under wich business operates:	Corporation ☐	Partnership ☐	Proprietorship ☐
If division.subsidiary, Name of Parent Company:			

BILLING/MAILING INFORMATION

Street Address:			
City:	State:	Zip/Postal Code:	
Individual or department responsible for payment of freight charges:			
Phone:	Extension:	Fax:	E-mail:
Approximate Number of Shipments Per Month:	Inbound:	Outbound:	
Billing Requirements:			

VENDOR REFERENCES

Company Name:	Company Name:	Company Name:
Contact Name:	Contact Name:	Contact Name:
Address:	Address:	Address:
City, State, Zip	City, State, Zip	City, State, Zip
Phone:	Phone:	Phone:
Fax:	Fax:	Fax:
Email:	Email:	Email:

All information on this form will be held in confidence

Please allow 2-3 weeks for processing.
We will notify you if terms have been approved or denied, the days allowed and the credit limit.

I hereby certify that the information contained herein is complete and accurate. This information has been furnished with the understanding that it is to be used to determine the amount and conditions of the credit to be extended. Furthermore, I hereby authorize the financial institutions listed in this credit application to release necessary information to the company for which credit is being applied for in order to verify the information contained herein.

________________________ Signature

________________________ Date