

Distributor Application

Would you like to partner with Custom Craftworks?
Become a distributor and serve massage therapists,
estheticians, and health practitioners who use our
products to enhance their practices.

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Phone: 800.627.2387
Fax: 541.345.4377



Mailing: 5729 Main Street #238
Physical: 800 48th Street, Suite B
Springfield, OR 97478



www.CustomCraftworks.com





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Dealer Contact Sheet

Sales & Quotes

Contact Lisa at
lisae@pivotalhealthsolutions.com
or 605-878-0527

Customer Service

Contact Kelly at
kelly@customcraftworks.com or
458-205-8782

When e-mailing finalized orders and PO, please
send to lisae@pivotalhealthsolutions.com and
always CC kelly@pivotalhealthsolutions.com

Service & Warranty

Contact Tammy or Julie at
service@customcraftworks.com
605-753-4804 (Tammy) or
605-753-3652 (Julie)

Shipping Quotes

Contact Ashley at
ashleyh@pivotalhealthsolutions.com
or 605-882-8397



Mailing Address
5729 Main Street #238
Springfield, OR 97478
Fax (541)345-4377



Physical Address
800 48th St. - Suite B
Springfield, OR 97478



Office Hours are
Monday - Friday
7 am to 4 pm PST.
We are closed most
major holidays.



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Wholesale Distributor Application

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Company Name
Website
Federal Tax ID #

Primary Contact Information

Contact Name	
Position/Title	
Phone	Extension
Email	Fax

Billing

Same as above? Yes No

Billing Address			Suite
City	State	Zip	Country
Billing Contact	Email		
Phone	Extension	Fax	

Preferred Payment Method	Would you like a Credit Application for Net30 Terms? <input type="checkbox"/> Yes <input type="checkbox"/> No
Preferred Shipping Method <input type="checkbox"/> Drop Ship <input type="checkbox"/> Use your own account(s) <input type="checkbox"/> Stock & ship from own inventory	
Do you sell online? <input type="checkbox"/> Yes <input type="checkbox"/> No Website(s):	Do you have a catalog? <input type="checkbox"/> Yes <input type="checkbox"/> No
Do you attend Trade Shows? <input type="checkbox"/> Yes <input type="checkbox"/> No List Show attended:	Do you advertise or have a newsletter? <input type="checkbox"/> Yes <input type="checkbox"/> No Describe:

Shipping

Same as above? Yes No

Shipping Address			Suite
City	State	Zip	Country

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Sales Contact Information

Contact Name	Phone
Email	

Product Information Contact Information

Contact Name	Phone
Email	

Company Sales Profile

Reasons for your interest in CCW products:
List brands you currently offer:
Quantity of tables you keep in stock:
Quantity of tables you sell per year:
Quantity of CCW tables you expect to sell per year:
From which educational or healthcare institutions do you draw potential customers?
What percentage of your sales are made to non-students?
What is the most popular brand of tables you offer?
Reason:
Which PHS brands are your interested in?

Which best describes your company's approach to equipment sales? <input type="checkbox"/> Let the customer look over the products and brochures and then choose for themselves <input type="checkbox"/> Promote the equipment that makes the most money for your business <input type="checkbox"/> Consult with customers and help them make an informed choice <input type="checkbox"/> Educate customers about the full range of choices and differences in performance relative to their intended use of the product
What are your business hours and time zone?

Which of the following activities do you participate in to promote your business? (Check all that apply) <input type="checkbox"/> Trade Shows <input type="checkbox"/> Internet Advertising <input type="checkbox"/> Local Advertising <input type="checkbox"/> Trade Journal Advertising <input type="checkbox"/> Other (Please specify):
Please list the email address you prefer to receive updates such as new price lists and catalogs:

This application has been completed by:	
Name	Position/Title
Signature	Date
<input type="checkbox"/> Please initial if you would like us to offer a line of credit (which requires a credit check and credit application)	

Please fax completed application to 541-345-4377 or sales@customcraftworks.com



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Fax: 541.345.4377



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Credit Application

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Credit terms of 30 days may be established upon approval by completing this application. Please type or print all information and sign and date the form. If you choose to provide your own reference sheet, FAX NUMBERS & SIGNATURE are REQUIRED. Application will be returned if fax numbers for references are not included and it is not signed.

Fax or e-mail completed form to 541-345-4377 Attn: Credit Department. Or e-mail to accounting@customcraftworks.com.

Name	Phone	Fax
Street Address		
City	State	Zip
Type of business	Year Business Established	
Email		
Ownership (check one) <input type="checkbox"/> P.A. <input type="checkbox"/> Sole Proprietor <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation		

Principals

	Title
	Title
	Title
Contact for further company information	Phone

References (Fax numbers required)

Business #1	
Phone	Fax
Account #	

Business #2	
Phone	Fax
Account #	

Business #3	
Phone	Fax
Account #	

Bank	
Account Manager	
Phone	Fax
Checking Accounts	
Loan Accounts	

Federal Tax I.D.		
Additional Comments:		
The above representations have been made to Pivotal Health Solutions for the purposes of obtaining credit and to the best of my knowledge are accurate in all respects. I authorize you to verify the credit information with my bank(s) and business references. Upon approval of credit terms, the payment for all sales of goods will be according to the terms stated on the invoice. In the event of a delinquency, all collection expenses and attorney's fees in connection with the collection of the delinquent debt shall be due and payable by the Applicant. The interpretation of this agreement shall be subject to the laws of the State of Oregon, and any necessary legal action shall be brought in Lane County, Oregon.		
Signed by	Title	Date