Distributor Application



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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

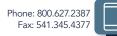
Would you like to partner with Custom Craftworks? Become a distributor and serve massage therapists, estheticians, and health practitioners who use our products to enhance their practices.

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Dealer Contact Sheet

Sales & Quotes

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

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

Service & Warranty

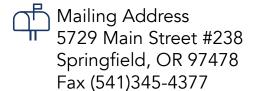
Contact Tammy or Julie at service@customcraftworks.com 605-753-4804 (Tammy) or 605-753-3652 (Julie)

Customer Service

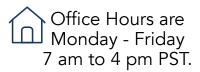
Contact Kelly at kelly@customcraftworks.com or 458-205-8782

Shipping Quotes

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

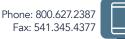


Physical Address 800 48th St. - Suite B Springfield, OR 97478



We are closed most major holidays.













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?						
Billing Address				Suit	re	
City	State		Zip		Country	
Billing Contact	Email					
Phone	Extension			Fax		
Preferred Payment Method		Would you like	a Credit Ap	plica	ation for Net30 Terms? Yes No	
Preferred Shipping Method Drop Ship Use you	r own acco	ount(s) Stock	& ship from	own	inventory	
Do you sell online? Yes No Website(s):	Do you have a cata	o you have a catalog?				
		Do you advertise o Describe:	o you advertise or have a newsletter? Yes No escribe:			
Shipping Same as above?						
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 cus	comers?				
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? Let the customer look over the products and brochures and then choose for themselves Promote the equipment that makes the most money for your business Consult with customers and help them make an informed choice 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) Trade Shows Internet Advertising Cother (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				
Please initial if you would like us to offer a line of credit (which requires a credit check and credit application)					



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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) P.A. Sole Proprietor Partnership Corporation								
Principals								
		Title						
		Titl	e					
		Title						
Contact for further company informa	Contact for further company information Phone							
Defenence /Fox numbers neguined)								
References (Fax numbers required)								
Business #1			Business #2					
Phone	Fax		Phone Fax		av			
Account #	I dx		Account #		dA .			
7 tecount ii			/ teedune #					
Business #3		Bank						
			Account Manager					
Phone	Fax		Phone		F	ax		
Account #			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		Т	ïtle			Date		