



CREDIT APPLICATION
Please Print Clearly

Please fax/send to Accounts Receivable
Rosedale Transport Inc.
 1821 Wendell St. P.O. Box 3427
 Dalton, GA 30721
 Tel.: 706-226-1003 / Fax: 706-226-4641

FOR INTERNAL USE ONLY. PRIVATE AND CONFIDENTIAL.
THE INFORMATION FURNISHED WILL REMAIN CONFIDENTIAL AND WILL BE USED SOLELY FOR CREDIT PURPOSES.

| |
|--------------------------|
| Internal Use Only |
| _____ |

Company Name: _____ Code: _____

Doing Business As: _____

Address: _____

City: _____ Prov./State: _____ Postal Code/Zip: _____

Tel.: (____) _____ Fax: (____) _____ Toll Free: _____

Billing Address: (If Different From Above) _____

City: _____ Prov./State: _____ Postal Code/Zip: _____

Accounts Payable Contact: _____ Tel.: (____) _____ Fax: (____) _____

Name of Person Making Application: _____ Position: _____

| | Name(s) of Proprietor(s) or Officer(s): | Title | |
|----|---|-------|--|
| 1. | _____ | _____ | Check One of the Following: <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Proprietorship In business since: _____ Month _____ Year |
| 2. | _____ | _____ | |
| 3. | _____ | _____ | |

Trade References: *Please provide one transportation company as a reference.*

1. Name: _____ Tel.: (____) _____

Address: _____ Fax: (____) _____

2. Name: _____ Tel.: (____) _____

Address: _____ Fax: (____) _____

Trucking Company Reference:

Name: _____ Tel.: (____) _____

Address: _____ Fax: (____) _____

Bank Reference:

Bank: _____ Branch: _____

Acct. Mgr.: _____ Tel.: (____) _____ Fax: (____) _____

Invoices due upon receipt and delinquent at thirty (30) days. A service charge of 2% per month will be charged on overdue accounts. I/we make application for credit terms and certify that the information given for the purpose of opening this account are true. I/we authorize verification of the above facts.
I/we will be responsible for all related costs if my/our account is placed in collection or goes to litigation.

Signature of Applicant

Estimated Freight Volume Per Month: \$ _____ Signature of Sales Associate: _____

| FOR INTERNAL USE ONLY | | | | | |
|-----------------------|-----|-----------------------|-----|-----------------------|-----|
| Date Approved/Revised | By: | Date Approved/Revised | By: | Date Approved/Revised | By: |
| | | | | | |
| \$ Amount | | \$ Amount | | \$ Amount | |

Please use back for notes or additional information.