



**AFFILIATE APPLICATION**

**Ph: 855-237-2500**  
P.O. Box 749, Freeport, NY 11520

*Please tell us a little bit about yourself.*

Company Name: \_\_\_\_\_

Address: \_\_\_\_\_ Suite: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

Email: \_\_\_\_\_ Web site: \_\_\_\_\_

EIN/SS #: \_\_\_\_\_

Contact Person: \_\_\_\_\_

Title: \_\_\_\_\_

Years in Business: \_\_\_\_\_ Number of employees: \_\_\_\_\_

Type of business: \_\_\_\_\_

Geographic radius of coverage: \_\_\_\_\_

\_\_\_\_\_

Current Products or Services sold: \_\_\_\_\_

\_\_\_\_\_

Do you have a listing with Better Business Bureau: \_\_\_\_\_

Marketing Plan for Our Products: \_\_\_\_\_

Do you market on the Internet: \_\_\_\_\_ Do you do Tele-Marketing: \_\_\_\_\_

Do you Direct Mail Advertising: \_\_\_\_\_ Do you sell PERS now: \_\_\_\_\_

Do you sell Medication Monitoring now: \_\_\_\_\_

3 Trade References: (Name, Address, Phone & Contact Person)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

3 Personal References: (Name, Address, Phone & Contact Person)

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