DATE: _____

SALES REP NAME/ID: HomeCare Provider Services

2026 Dealer Account Application

Dealer Information	
Dealer Name:	Business Name:
Billing Address:	Shipping Address:
Street:	Street:
City, State, Zip Code:	City, State, Zip Code:
Country:	Country:
Telephone:	Telephone :
Fax:	Fax:
Email:	Email:

Type of Business (Circle One)
☐ Corporation ☐ Partnership ☐ Proprietorship
Business Information
How long in business?
Primary business activity:
How long at this address?
Tax Exempt #
Fed ID or SS#

Bank Information
Bank Name:
Bank Location, City:
Telephone:
State, Zip Code:
Account #:
Bank Contact:
How long with this bank?

Trade References: (Please list two)	
1. Name	Telephone
Address, City	State, Zip Code
Type of account	Annual Volume
2 . Name	Telephone
Address, City	State, Zip Code
Type of Account	Annual Volume

Officers/Partners: (Please list two)	
1. Name	Telephone
Address, City	State, Zip Code
Title	
2 . Name	Telephone
Address, City	State, Zip Code
Title	

Signed by an Officer of the Company:

NAME _____ TITLE _____

SIGNATURE _____ DATE _____

STRONGBACK MOBILITY USA, LLC

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