



DIRECT BILL APPLICATION

BUSINESS INFORMATION			
NAME OF BUSINESS		NUMBER OF EMPLOYEES	IN BUSINESS SINCE
LEGAL NAME (IF DIFFERENT)		CONTACT PERSON	DO YOU USE P.O.'S?
ADDRESS		CORPORATION, PARTNERSHIP, PRIOPRIETORSHIP, LIMITED LIABILITY COMPANY (CIRCLE ONE)	
CITY	STATE	ZIP CODE	DESCRIPTION OF BUSINESS
PHONE	FAX	EMAIL	AUTHORIZED DRIVERS

COMPANY PRINCIPLES RESPONSIBLE FOR BUSINESS TRANSACTIONS	
NAME:	TITLE:
NAME:	TITLE:

BANK & CREDIT CARD REFERENCE INFORMATION		
NAME OF BANK	CREDIT CARD NUMBER	EXP DATE
CHECKING ACCOUNT NO.	CREDIT CARD NUMBER	EXP DATE
PHONE	CREDIT CARD NUMBER	EXP DATE

CREDIT REFERENCES			
LESSOR/CREDITOR	CONTACT NAME	TELEPHONE NUMBER	ACCOUNT OPEN SINCE

INSURANCE CARRIER INFORMATION	
INSURANCE CARRIER:	POLICY NO.
CONTACT:	PHONE:

CONFIRMATION OF INFORMATION ACCURACY AND RELEASE OF AUTHORITY TO VERIFY		
<p>In making this application for Direct Billing, the customer agrees to pay all invoices within 15 days of the invoice date. The customer also agrees to pay 2% late charge on any unpaid balance every 30 days. It is fully understood that any unpaid balance after 60 days may be applied to any Credit Card used as security. The undersigned agrees to the above and accepts full responsibility of the same. <i>The undersigned is an officer of said Company/Corporation and is authorized to act for said Company/Corporation.</i></p>		
_____	_____	_____
SIGNATURE	TITLE	DATE

**POLICY STATEMENT: NEW ACCOUNTS WILL NOT BE PROCESSED
UNLESS ACCOMPANIED BY THE ABOVE REQUESTED INFORMATION
TERMS: NET 15 DAYS OF INVOICE UNLESS OTHERWISE STATED**

CHATSWORTH	SIMI VALLEY	VENTURA	SANTA CLARITA
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