GENICEL INC.
Manufacturers of ProBoost®

NEW ACCOUNT APPLICATION

Company Name:

Contact Person (First Name, Last Name):

Shipping Address:

City: State: Zip:

Telephone: Fax:

Email Address(es):

Website:

Federal ID or SS#: Seller's Permit No.:

Billing Address: Same as above? ☐ Yes ☐ No

If different:

Credit Card Number: CRV: Exp. Date:

This is an authorization of ongoing automatic charges to our account by your company. By signing below, I acknowledge charges described hereon.

Signature of Card Holder

Name of Card Holder

The undersigned individual declares the above information to be true and correct.

Signature: Date:

Print Name:

Please email as a PDF to info@proboostmed.com or fax to (951) 346-5575 to complete this application.