VITALITY DEPOT

Posture Medic®

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POSTURE MEDIC DISTRIBUTOR APPLICATION

Thank you for your interest in becoming a distributor for Posture Medic.

COMPANY PROFILE

Company Name:	**Street:**	**Country:**
City:	**Province:**	**Postal Code:**
Year Company Started:	**Corporation** ☑ **Partnership** ☑ **Government** ☑ **Sole Proprietorship** ☑	
Telephone:	**Fax:**	**Website:**

Does your website require a login? ❑ **Yes** ❑ **No** **Username:** **Password:**

Years in Business:	**Number of Employees:**	**Number of Sales People:**
Projected Revenue for this Year:	**Last Year's Revenue:**	

Type of Business: ❑ **Distributor** ❑ **Manufacturer** ☑ **Retail** ☑ **Healthcare** ☑ **Online**

Does the company have Distributors?	❑ **Yes**	❑ **No**	**If so how many?**
Does the company supply Retail Stores?	❑ **Yes**	❑ **No**	**If so how many?**
Does the company supply Clinics/Healthcare?	❑ **Yes**	❑ **No**	**If so how many?**
Does the company exhibit at Consumer Tradeshows?	❑ **Yes**	❑ **No**	**If so how many?**

What region in Canada do you do business in?

Top 5 Current Products:

1. _____ 2. _____ 3. _____ 4. _____ 5. _____

TRADE REFERENCES

Company Name:	**Contact:**	**Annual Purchase:**
Company Name:	**Contact:**	**Annual Purchase:**

COMPANY CONTACT INFORMATION

Sales:	**Phone:**	**Email:**
Purchasing:	**Phone:**	**Email:**
Shipping/Logistics:	**Phone:**	**Email:**
Marketing/Graphics:	**Phone:**	**Email:**

APPLICANT INFORMATION

Name of Applicant:	**Phone:**
Email of Applicant:	**Date:**