CUSTOMER APPLICATION FORM

* Indicates a requirement from Credit Management to open a new account.

Alcon

Alcon Laboratories, Inc.
6201 South Freeway - TC-02
Fort Worth, Texas 76134 USA

Attention: Data Management
Phone: 1-800-862-5266 Ext. 31587
Fax: 1-800-757-4954 E-Mail: customer.profile@alcon.com

SHIP TO NAME AND ADDRESS*

LEGAL NAME:		DBA *(IF APPLICABLE)*:	
PARENT COMPANY, HEALTH NETWORK/SYSTEM, CORPORATE GROUP *(IF APPLICABLE)*:			
LEASEHOLDER, FRANCHISE, STORE#, OPTICAL NETWORK *(IF APPLICABLE)*:			
ADDRESS:		ATTN:	
CITY:	STATE:	ZIP:	COUNTY:
PHONE #: ( )		FAX # *(IF APPLICABLE)*: ( )	
EMAIL ADDRESS:		BUSINESS WEBSITE *(IF APPLICABLE)*:	

BILL TO NAME AND ADDRESS* ❑ SAME AS SHIP TO ADDRESS

LEGAL NAME:		DBA *(IF APPLICABLE)*:	
ADDRESS:		ATTN *(IF APPLICABLE)*:	
CITY:	STATE:	ZIP:	COUNTY:
A/P CONTACT:		EMAIL ADDRESS:	
PHONE #: ( )		FAX # *(IF APPLICABLE)*: ( )	
FEDERAL TAX IDENTIFICATION NUMBER *(REQUIRED)*:			

ALTERNATE PAYMENT METHOD

*For direct Alcon purchases only, does not include distributor account information. Not applicable with Optical Network memberships.

CONTACT LENS BUYING GROUP:	
MEMBER #:	DATE JOINED:

OPTICAL NETWORK	SURGICAL NETWORK
OPTICAL NETWORK:	GPO/BUYING GROUP:
MEMBER/ACCT #:	MEMBER/ACCT #:

PRACTICE PURCHASE/OWNERSHIP CHANGE

If this is an ownership change of the practice/business, please list the previous owner's information below.

PREVIOUS NAME *(IF APPLICABLE)*:	ACCOUNT #:
DATE OF OWNERSHIP CHANGE:	

PREVIOUS ALCON CUSTOMER*

HAVE YOU EVER HAD AN ACCOUNT WITH ALCON? ❑ NO ❑ YES	IF SO, WHEN?
NAME *(IF APPLICABLE)*:	ACCOUNT #:

LICENSING INFORMATION

NAME OF LICENSED PRESCRIBER:	
SPECIALTY (Optometry, Ophthalmology, etc.):	
PHYSICIAN STATE LICENSE #:	DEA #:
LICENSE PERMIT # (Hospitals, Surgery Centers, etc.):	

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ORDERING INFORMATION

WHAT ALCON PRODUCTS ARE YOU INTERESTED IN PURCHASING? ❑ OVER-THE-COUNTER (I.E. OPTI-FREE®, SYSTANE®, etc.)
❑ CONTACT LENSES ❑ PHARMACEUTICAL ❑ SURGICAL ❑ OTHER

TYPE OF BUSINESS: ❑ HOSPITAL *If HOSPITAL, check one of the following:* ❑ *GOVT.* ❑ *INDEPENDENT* ❑ DR.'S OFFICE ❑ SURGICENTER
❑ OPTOMETRIST ❑ OPTICIAN ❑ OPHTHALMOLOGIST ❑ OTHER (PLEASE SPECIFY):

DO YOU ACCEPT BACKORDERS? ❑ NO ❑ YES *If YES, do you allow partial delivery per item?* ❑ *YES* ❑ *NO*

DO YOU HAVE PRODUCT DATING MINIMUM REQUIREMENTS? ❑ NO ❑ YES (❑ 9 months ❑ 12 months) (WFS, WVX, RPC)

DO YOU WANT TO TRANSMIT ORDERS VIA EDI? ❑ NO ❑ YES

DO YOU ALLOW PRODUCT SUBSTITUTIONS? ❑ NO ❑ YES

IF PRODUCT SUBSTITUTIONS ALLOWED, PLEASE INDICATE:
UPC CHANGE ❑ NO ❑ YES DIMENSION CHANGE ❑ NO ❑ YES REBATE IN/ON PACK ❑ NO ❑ YES

FORMATTED PO REQUIRED? ❑ NO ❑ YES

DELIVERY INFORMATION

DO YOU REQUIRE PRESCHEDULED DELIVERY APPOINTMENTS? ❑ NO ❑ YES
ADVANCED NOTICE REQUIREMENT: PHONE #:

FINANCIAL INFORMATION*

FORM OF BUSINESS (CORPORATION, PARTNERSHIP, SOLE PROPRIETOR, ETC.):

NUMBER OF YEARS IN BUSINESS:

STATE OF INCORPORATION OR REGISTRATION:

PRINCIPALS OR OFFICERS (LIST BELOW):

NAME:	TITLE:
NAME:	TITLE:
NAME:	TITLE:

PLEASE ATTACH A COPY OF YOUR MOST RECENT FINANCIAL STATEMENTS OR BUSINESS TAX RETURNS

ESTIMATED MONTHLY PURCHASES FROM ALCON *(REQUIRED)*: $

DO YOU HAVE A STATE TAX EXEMPT CERTIFICATE? ❑ NO ❑ YES IF YES, PLEASE ATTACH A COPY (THE INFORMATION PROVIDED WILL SUPPORT ANY FUTURE REQUESTS FOR CREDIT LINE INCREASE AND/OR EQUIPMENT PURCHASES)

HAS THE BUSINESS OR ANY OFFICERS FILED A PREVIOUS BANKRUPTCY? ❑ NO ❑ YES

IF YES, PROVIDE THE COMPANY NAME AND DATE FILED:

BANKING INFORMATION*

BANK NAME:

CONTACT:		ADDRESS:	
CITY:	STATE:	ZIP:	PHONE:

TRADE VENDOR REFERENCES*

COMPANY:	CONTACT:	PHONE #:
COMPANY:	CONTACT:	PHONE #:
COMPANY:	CONTACT:	PHONE #:

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Alcon requires that this information be provided for account consideration. Completion of this form, however, does not indicate that a request will be granted.

Customer acknowledges and agrees that the signing of this Customer Application Form shall constitute authorization under the Fair Credit & Reporting Act to Alcon and its Agents to utilize outside credit reporting agencies to provide reports on Customer in order to permit Alcon to appropriately evaluate the extension of any business credit. Alcon may also confirm trade and bank references.

Customer agrees to release of information to other creditors and reporting agencies regarding Alcon's credit experience with them. This authorization will remain valid and enforceable until Customer expressly revokes said authorization in writing to Alcon.

Customer agrees to pay all charges according to the payment terms as designated on Alcon's invoices.

TERMS AND CONDITIONS AGREEMENT
Applicant agrees to pay according to terms and conditions stated herein. Creditor reserves the right to assess a monthly service charge on account paid outside of credit terms to the maximum amount permitted per jurisdiction. Creditor reserves the right to cease extension of credit without notice or to change terms of payment pursuant to any disclosure by customer according to section 409 of the Sarbanes Oxley Act. Applicant expressly agrees that it shall be liable and pay all attorneys' fees, collection costs and court fees, and any other expenses, whether or not incurred in connection with litigation, including but not limited to attorneys' fees and costs associated with the enforcement of any of the terms of this Application and attorneys' fees and costs resulting from a default under this Application.

The above information is being provided in conjunction with a request of open credit terms from Creditor and its subsidiaries, divisions and affiliates (collectively "Creditor"). I hereby certify under penalty of perjury that the information provided is true to the best of my knowledge. The undersigned further understands that the Guaranty accompanying this Application is necessary to induce Creditor to extend credit to Applicant. If this Application is accepted by Creditor, the undersigned agrees to the terms and conditions attached to the Application and changed from time to time. The undersigned further agrees that all issues and disputes relating to any credit arrangement extended hereunder shall be governed in accordance with a competent jurisdiction chosen at the discretion of Creditor, without reference to conflicts of laws principles.

PRINT AND SIGN NAME (REQUIRED)

PRINT:	
SIGN:	
TITLE:	DATE:

FOR INTERNAL USE ONLY

INDUSTRY CODE:
VERIFIED BY:
DATE:

The personal information that you provide to Alcon Laboratories Inc., on the Customer Application from, will be used to permit Alcon to evaluate the extension of any business credit. Your personal information will be shared globally with Alcon associates, as necessary, for credit purposes and will be stored in the United States by Alcon or its authorized agents. If you choose to have your account information removed from our database at any time in the future or have any questions regarding the person data in this database, please forward your request to the address or email listed at the top of this form. By signing this document, you are agreeing to the collection, processing and disclosure of your personal data as described above and to our privacy policy.