New Distributor Application

Company Name: ____

Company Address: ____

____

____

Company Website: ____

Main Contact Name: ____

Position:____

Tel: ____________________ Fax:_____________________ Email:_____________________________

Specialty Line of Products (i.e. Laparoscopic, Ortho, etc): ___________________________________

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Gross Annual Sales for 2010: __________________________ No. Sales Reps____________________

Requested Territory (US/International): ____

If outside US, will you take responsibility for registering Apollo's products in the territory listed above?: **Yes / No**

How did you hear about Apollo Surgical Industries, Inc? ____________________________________

Please also include the following documents:

- Copy of Business License