BioCyteDiagnostics

ACCOUNT INFORMATION FORM

ACCOUNT INFORMATION (Required fields are marked with an asterisk.)

ACCOUNT NAME*:

PHONE*: FAX:

STREET ADDRESS*: CIT*:

STATE*: ZIP*:

CREDIT CARD INFORMATION

NAME ON CREDIT CARD*:

CREDIT CARD TYPE*: CREDIT CARD #*:

EXP*: CVV CODE*:

STREET ADDRESS*: CITY*:

STATE*: ZIP*:

I hereby request and authorize BioCyte Diagnostics, LLC, to apply payments of all invoices to the credit card listed above. Card member agrees to perform to obligations set forth in the Card member's agreement with the issuer. All dales are final Errors must be reported to BioCyte Diagnostics, LLC within 48 hours of receipt for exchange. Payments are applied on date of shipment. In consideration of and in order to induce you to establish an open account line of credit based on the foregoing application, the undersigned promises to pay for monthly purchases in accordance with your terms of sales. If at any time, for any reason, the undersigned is unable to pay for monthly purchase when due, the undersigned agrees to pay and authorizes you to bill my/our account, interest computed at the legal rate against any past due amount owing on my/our account in the event it becomes necessary for your company to incur collection costs or institute suite to collect any amount due under this agreement, or any portion thereof, the undersigned promises to pay such additional collection costs, charges and expenses, including reasonable attorney's fees if the account is placed in the hands of any attorney for collection. Furthermore, the undersigned authorizes to charge all outstanding invoices to the signer's credit card on file.

SIGNATURE:

SIGNATURE DATE: