HALSTED HEALTH

# DISTRIBUTOR APPLICATION FORM (USA ONLY)

Complete and send to info@halstedhealth.com

Company Legal Name: _____

Years In Business: _____

Tax ID / EIN: _____

Address: _____

_____

State: _____

Zip Code: _____

Contact Person: _____

Title: _____

Email: _____ Phone: _____

Current Products Offered By Your Company: _____

_____

_____

Where / How Do You Currently Sell (Online / Offline): _____

_____

Annual Sales: _____

Halsted Health Products That You Are Interested In: _____

_____

How Many Sales Personnel Does Your Company Employ: _____

How Many Sales Personnel Will Be Involved In Selling Halsted Health Products: _____