



# Alkazone Global Inc.

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Tel: (201)880-7966 Fax: (201)880-7967  
(800)810-1888 www.alkazone.com

## Application for Dealership/Distributorship

Company Name: \_\_\_\_\_

Contact Name: \_\_\_\_\_ Title: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_

Business Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Tax ID: \_\_\_\_\_ SS #: \_\_\_\_\_

How long at Current Address? \_\_\_\_\_ Any Other Locations: \_\_\_\_\_

Company web site : \_\_\_\_\_

### **Business Type:**

Sole Proprietorship: \_\_ Partnership: \_\_ Corporation: \_\_ Doctor: \_\_ Individual: \_\_ Other: \_\_\_\_\_

Business Items: \_\_\_\_\_

Date business commenced: \_\_\_\_\_ Annual Sales:\$ \_\_\_\_\_

### **Where did you hear about Better Health Lab, Inc?**

Website: \_\_ Magazine: \_\_ Newspaper: \_\_ Friend: \_\_ Email: \_\_ Other: \_\_\_\_\_

Where do you plan on marketing these products? \_\_\_\_\_

How do you plan on marketing these products? \_\_\_\_\_

### **Business References:**

Company Name: \_\_\_\_\_ Contact Person: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Tel: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_

Company Name: \_\_\_\_\_ Contact Person: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Tel: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_

All information from this application is confidential and will be used to determine your Dealership /Distributorship eligibility with Better Health Lab, Inc. By signing this application you grant permission for Better Health Lab, Inc. to contact your references to further review your application.

Name: \_\_\_\_\_ Title: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_