

**Account Information  
Form**



**Please fax to:  
805.654.9978**

Business Name: \_\_\_\_\_

Name of Primary Contact: \_\_\_\_\_

Name of Secondary Contact: \_\_\_\_\_

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

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

Primary Phone \_\_\_\_\_

Secondary Phone \_\_\_\_\_

Fax \_\_\_\_\_

Email \_\_\_\_\_

Additional Phone \_\_\_\_\_

2nd Email \_\_\_\_\_

Special Delivery Instructions:

Special Billing Instructions:

Number of Licensed Esthetic Professionals:

Account Opening Date:

**Corporate Use Only**

Rep Code:

Direct Ship Program

VIP Level

County

State

Zip

CC Auth

T & C

License Agreement

Website: