

MAXCELINT® Dealer Application

Dealers & Licensed Professionals

MAXCELINT Assigned Authorized Dealer Account Number _____

Name of Business _____

Owner/Authorized Representative Name _____

E-Mail Address: _____ Phone # (____) _____

Business Address:

Number & Street _____ Suite _____

City _____ State _____ Zip _____

Shipping Address (if different than Business Address):

Number & Street _____ Suite _____

City _____ State _____ Zip _____

Do you have a Store Front operation? Yes _____ No _____

How long have you been in business? Years _____ Months _____

How many retail outlet locations do you currently have? _____

Do you sell other Dietary Supplement Products? Yes _____ No _____

Current annual sales volume of Dietary Supplement Products? \$ _____

CA Dealers: Have a CA Seller's Permit? Yes _____ (if yes, provide copy) No _____

I do hereby certify that all statements provided herein are true and accurate. It is the intent of the above named business entity to purchase **MAXCELINT Dietary Supplement Products** at wholesale and resell them at retail, rather than for my own personal use or for any other purpose. The business entity and its representatives fully agree to not disseminate, in any form or medium, any product information other than what is stated on the **MAXCELINT** website, and specifically to not reveal or give to anyone or any other entity the **Confidential MAXCELINT Dealer's Wholesale Price List**. The business entity recognizes that all Intellectual Property (patents, trademarks & copyrights) are the exclusive property of Maxcelint Laboratories Inc. (MLI) with all rights reserved. I do hereby agree to all of the above, and understand that this application is subject to MLI acceptance and is governed by the laws of the State of California.

Owner/Authorized Representative Signature _____ **Date** _____