



# M&S FOODS

**Innovative Food Distribution Systems and Marketing**

**M & S Foods**

P.O. Box 141916

Gainesville, FL 32614

Toll Free (866) 336-5397

Office: (352) 332-5166 \* Fax: (352) 331-8958

**New Account Form**

**BILL TO: SHIP TO:**

Business Name Corporate Name

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Address Trade Name

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City, State, Zip Street Address

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In Case of Billing Problem Contact City, State, Zip

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Business Phone \_\_\_\_\_

Tax Exempt Number \_\_\_\_\_

1. Type of Operation: \_\_\_\_\_

10)  Restaurant 40)  Concessions & Catering 75)  Summer (Seasonal) Camps

15)  Division of Blind Services 50) Grocery Store 80)  Drug Stores

20)  Hospital & Rest Homes 55)  Day Care Centers 85)  Government

25)  Sororities & Fraternities 60)  Convenience St & Gas St. 90)  Correctional Facilities

30)  School 65)  Inter-Company 95)  Senior Citizen Services

35)  Churches 70)  Bars 99)  Miscellaneous

2. Franchise?  Yes  No

3. Seasonal Business?  Yes  No Months Closed \_\_\_\_\_

4. Operating Hours: \_\_\_\_\_ AM PM To \_\_\_\_\_ AM PM  S  M  T  W  T  F  S

5. Special Delivery Instructions (if any):

6. Number of Seats (Or Beds if Health Care):  1 to 25  25 to 50  50 to 100  Over

7. Weekly Food Purchases:  Under \$500  \$1,000-\$2,000  \$2,000-\$5,000  Over \$5,000

8. Who has the authority to receive deliveries?  Any Employee

Specific Employee

(specify) \_\_\_\_\_

9. Who has the authority to place an order? \_\_\_\_\_

Title \_\_\_\_\_

Who has the authority to pick up order? \_\_\_\_\_

Title \_\_\_\_\_

10. Who has the authority to purchase new items? \_\_\_\_\_

Title \_\_\_\_\_

11. Have we done business at this location before?  Yes  No

12.  Proprietorship  Partnership  Corporation

13. Name of Bank \_\_\_\_\_

Branch \_\_\_\_\_

Account # \_\_\_\_\_

14. Complete the following information on all corporate officers, partners, or individual Proprietor.

Attach additional sheets if necessary.

\_\_\_\_\_  
\_\_\_\_\_

Name and Title

\_\_\_\_\_  
\_\_\_\_\_

Home Address

\_\_\_\_\_  
\_\_\_\_\_

City, State, Zip

\_\_\_\_\_  
\_\_\_\_\_

Home Phone

\_\_\_\_\_

Social Security# \_\_\_\_\_

15. Item 15 to be completed by Sales Representative ---- DATE: \_\_\_\_\_

Salesman \_\_\_\_\_ Salesman No.: \_\_\_\_\_

Zone: \_\_\_\_\_ Route: \_\_\_\_\_