KENT SURGICAL

Committed to Innovation

Kent Surgical Distributor Application Form

Kent Surgical sincerely appreciates your interest in partnering with us as a distributor. We value our partnerships and work closely with our partners to ensure mutual success. Please complete the following application form. All information provided will be treated with strict confidentiality.

Basic Information

Company Name: _____

Company Address: _____

Contact Number: _____

Fax: _____

Email Address: _____

Website: _____

Legal Structure: _____

Year of Establishment: _____

Authorized Contact Person

Name: _____

Designation: _____

Phone Number: _____

Email Address: _____

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Company Profile

Business Activities: _____

Years in Business: _____

Number of Employees: _____

Annual Revenue (Last 3 Years): _____

Current Product Lines Distributed: _____

Companies Currently Represented: _____

Proposed Area/Country of Coverage

Specific Region or Country: _____

Number of Sales Specialists: _____

Location of Warehouse(s): _____

Supporting Documents

- ☐ Valid Trade License
- ☐ ISO Certificates (If any)
- ☐ Company Brochure
- ☐ Any other relevant certifications

Agreement

I confirm that the information provided above is accurate and agree to the terms of confidentiality.

Authorized Signature: _____ Date: _____

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كينت للصناعات الجراحية ذ.م.م
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العين، أبوظبي، الإمارات العربية المتحدة