



DISTRIBUTION PARTNERSHIP APPLICATION

Company Name:

First Name: Last Name: Title:

Business Address: City:

Zip/Postal Code: State/Province: Country:

Website:

Social Media:

Telephone:

Email:

How many years have you been in business?:

- 0-1 years
- 5-10 years
- 10-15 years
- 15-20 years
- 20+ years

Do you currently carry GORILLA gloves?: Yes No If yes, through whom:

Tax ID#:

Any additional information/comments:

Notice: Your location is very important to us because we may have other distributors in your area that we need to take into consideration. If this is the case we will do an analysis of that distributor before making our final decision to take you on as an GORILLAGLOVE INC. reseller.