



PERSONAL CARE CONSULTANT (PCC) APPLICATION FORM

Instructions: Please print clearly and answer all questions.

Last Name: _____ First Name: _____ M.I.: _____

Business Name (If applicable): _____

Gender: ___ M ___ F Date of Birth: ____/____/____ (MM/DD/YYYY)

S. S. N./E.I.N.: _____ D. L. number: _____ D.L. State: _____

Texas Tax ID (If applicable): _____

PCC or Store Address: _____

City: _____ State: _____ Zip Code: _____

Tel: _____ E-mail: _____

Referred by: _____

Please check Whole Sale N/P Independent

Distribution Method (beauty salon, store, person to person, etc.): _____

Please check: Cash Visa MasterCard American Express Discover Other (Specify): _____

\$100 Start up Kit: includes administrative set up, product set, 250 brochures, and products education.

Target Customers: _____

By signing this application form I certify that all the information provided above is true to my knowledge.

Signature: _____ Date: _____

Disclaimer: All information gathered by Kasny Recon, Inc. will remain confidential and will not be shared with any third party without a written consent of the applicant.

For KR official use only:

Approval: ___ Yes ___ No PCC ID number: _____

Approved by: _____

Signature: _____ Date: ____/____/____