



LEASE CREDIT APPLICATION

FULL LEGAL PRACTICE DOCTOR OR BUSINESS NAME		Fed Tax ID #	DBA NAME (If Applicable)		
BILLING ADDRESS		COUNTY	CITY	STATE	ZIP
PHONE		CELL PHONE	Email		
EQUIPMENT LOCATION (IF DIFFERENT FROM ABOVE)				Contact	
TITLE		YEARS IN BUSINESS OR LICENSED		STATE OF REGISTRATION	
"S" CORP "C" CORP SOLE PROPRIETOR PARTNERSHIP L.L.C L.L.P OTHER _____					

OFFICERS/OWNERS/PARTNERS/PROPRIETORS OR MEMBERS INFORMATION

PRINCIPAL NAME			% OWNERSHIP	PRINCIPAL NAME if Applicable (2)			% OWNERSHIP
SOCIAL SECURITY #				SOCIAL SECURITY #			
STREET ADDRESS				STREET ADDRESS			
CITY	STATE	ZIP		CITY	STATE	ZIP	
HOME PHONE #				HOME PHONE #			

LEASE INFORMATION FOR ADVANCED MEDICAL EQUIPMENT

AMOUNT WISHING TO FINANCE	LEASE TERM _____ MONTHS	DEFERRED PROGRAM yes NO
# OF ADVANCE PAYMENTS 0 1	10% \$100 OTHER	LEASE PAYMENT _____
EQUIPMENT DESCRIPTION		

BANK REFERENCE

Bank Name	Address (City/State)	Checking/Loan Acct #	Bank Phone #	Loan Officer
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CREDIT INFORMATION RELEASE

The undersigned authorizes and instructs any person, consumer reporting agency or financial institution to compile and furnish the lessor with any information it may have in response to any inquiry from the lessor, or its assignees. I/We further certify that under penalty of law that all of the above statements are true and complete and are for the purposes of obtaining credit from Advanced Medical. The applicant (lessee) certifies to Advanced Medical that it is applying for credit for business purposes, and not for personal, family or home use.

Signature _____ Print _____ Date _____

FAX COMPLETED APPLICATION TO: (425) 788-4499

OR CONTACT

LEE ATKINS: (425) 844-1189