



Healthcare Financial Services

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 Phone 800-573-7796 ♦ Fax 800-250-6967  
 Email To: [Credit@LPIHealthcareFinancial.com](mailto:Credit@LPIHealthcareFinancial.com)

**WEB - MEDICAL LEASING CREDIT APPLICATION**

AMOUNT	TERMS	DATE NEEDED	BUSINESS STRUCTURE	TYPE OF PRACTICE
VENDOR NAME			VENDOR ADDRESS & PHONE	

EQUIPMENT DESCRIPTION: (Please disclose if equipment is New, Used, Reconditioned or Remanufactured)

**PRIMARY BUSINESS INFORMATION**

EXACT LEGAL NAME		DBA OR TRADE NAME		PRACTICE TIME IN BUSINESS
MAILING ADDRESS (STREET)		CITY	STATE	ZIP
EQUIPMENT ADDRESS (STREET)		CITY	STATE	ZIP
PRACTICE WEBSITE	FED TAX ID#	PRACTICE PHONE	PRACTICE FAX	CELL

	PRINCIPALS/OFFICERS/PARTNERS	SOCIAL SECURITY #	TITLE	Ownership%	HOME ADDRESS
1					
2					

	TRADE REFERENCE	TYPE OF TRADE	CONTACT PHONE	CONTACT NAME
1				
2				

	PRACTICE BANK	ACCOUNT NUMBER	CONTACT PHONE	CONTACT NAME

**AUTHORIZATION TO OBTAIN CREDIT INFORMATION**

Applicant warrants all credit and financial information submitted to **LPI HEALTHCARE FINANCIAL SERVICES, INC.** (here after referred to as **LPIH**) and/or its assignees to be true and accurate and hereby authorizes all banking institutions and credit reporting agencies to release necessary information via telephone, mail, Internet or facsimile as requested for purposes of making a credit decision. The undersigned individuals specifically authorize **LPIH** and/or it assigns to obtain personal credit bureau reports for the making, extension, or renewal of this credit decision or collection of the resulting account. A fax or photo copy of this authorization shall be valid as the original.

Signature

Print Name

Date