



Healthcare Financial Services

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 Email To: Credit@LPIHealthcareFinancial.com

WEB - WORKING CAPITAL LOAN CREDIT APPLICATION

DATE	AMOUNT	TERMS	DATE NEEDED	BUSINESS STRUCTURE	STATE INC	DATE INC
EXACT LEGAL NAME			DBA OR TRADENAME			
CONTACT NAME	EMAIL ADDRESS	PHONE NUMBER	CONTACT DAY	CONTACT TIME		
USE OF FUNDS						
PRIMARY BUSINESS INFORMATION						
STREET			CITY	STATE	ZIP	
WEBSITE			BUSINESS PHONE	BUSINESS FAX	TIME IN BUSINESS	
TYPE OF MEDICAL PRACTICE			LICENSE ISSUED	LICENSE NUMBER	STATE	
PRINCIPAL/OFFICER/PARTNER		SOCIAL SECURITY #	TITLE / % OWNED		HOME ADDRESS	
US CITIZEN	HOME OWNER	YEARS AT ADDRESS	HOME PHONE	CELL PHONE		
PRACTICE SPACE OWN OR RENT		MONTHLY PAYMENT	TIME IN LOCATION	FEDERAL TAX ID #		
PRACTICE BANK NAME		ACCOUNT #	TELEPHONE #	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