Healthcare Financial Services

2260 Rushmore Dr. ♦ Suite B-3 ♦ Marietta, GA ♦ 30062
Phone 800-573-7796 ♦ Fax 800-250-6967
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**