Fax: 305-557-1876 Phone: 305-558-9266

E Q U I P M E N T F I N A N C E ******** colocar el correo general de MEF *******

VENDOR: Medical Equipment of Florida

QUICK-APP

Equipment Description _____ ***Estimated Cost: $*** _____

Legal Business Name	__Corp. __Sole Prop. __Partnership __LLC	Tax ID #	Years in Practice

Business Address	City	State	Zip	Business Phone #

Equipment Location *(If different):*

Annual Practice Gross Revenue: _____ *Annual Personal Net Income:* _____

# of Months (Term): _____ *Email Address:* _____

Dr. Name	Business Fax #	Social Security #

Home Address	City	State	Zip	Circle one: DVM-MD-DC-DPM-Other	**% of ownership**

I hereby authorize the release of business and/or personal credit information to FINANCIALCORP, its affiliates or assignees (1) from any source including credit bureau reporting agencies and my bank for the purpose of extending credit, (2) and to any credit reporting agency. Additionally I hereby authorize the release of my application without notice, to any other non-related potential lending sources for consideration of approval of credit. I hereby represent all information is true, correct and complete. A photo static and/or facsimile copy of this authorization shall be valid as the original.

Authorized Signature: _____ Date _____

Additional Principals (Owners):

2) Dr. Name	Social Security #

Home Address	City	State	Zip	Circle one: DVM-MD-DC-DPM-Other	**% of ownership**

3) Dr. Name	Social Security #

Home Address	City	State	Zip	Circle one: DVM-MD-DC-DPM-Other	**% of ownership**

4) Dr. Name	Social Security #

Home Address	City	State	Zip	Circle one: DVM-MD-DC-DPM-Other	**% of ownership**

5) Dr. Name	Social Security #

Home Address	City	State	Zip	Circle one: DVM-MD-DC-DPM-Other	**% of ownership**