



MEDICAL LEASE APPLICATION

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APPLICATION ONLY

FINANCIALS

FINANCIALS TO FOLLOW

Lessee:	
Address:	
Telephone #:	Facsimile #:
Contact:	Tax ID #:
Type of Business: Sole Proprietorship <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/>	
Years in Business:	Specialty/Type of Business:
Equipment Location:	
Vendor and Equipment Description:	Sales Representative and Phone Number::
Equipment Cost: \$	Term (Months): 24 <input type="checkbox"/> 36 <input type="checkbox"/> 48 <input type="checkbox"/> 60 <input type="checkbox"/> <input type="checkbox"/> Deferral: _____
Purchase Option: 10% <input type="checkbox"/> \$1.00 <input type="checkbox"/> FMV <input type="checkbox"/> FMV @ 10% <input type="checkbox"/>	

STOCKHOLDER/PERSONAL INFORMATION

Name:	Name:
Title:	Title:
Address:	Address:
Social Security #:	Social Security #:
Phone #:	Phone #:
Medical License #:	Medical License #:

BANK INFORMATION

Name:	Name:
Address:	Address:
Contact:	Contact:
Phone #:	Phone #:
Account #:	Account #:

To Globex Capital Group, Inc.:

The undersigned individual(s) who is/are either a principal, sole proprietor, or personal guarantor of the credit applicant, recognizing that his or her individual credit history may be a factor in the evaluation of the credit history of the applicant or in the evaluation of his or her personal guaranty, if application, hereby consents to and authorizes the use of a consumer credit report on the undersigned individual(s) by the above named business credit grantor, from time to time, as may be needed, in the initial credit evaluation and subsequent review processes.

 Applicant's Signature