



**Healthcare Equipment Lease & Loan Application**  
**Questions: Call 888-669-8008**

**Atlantic Commercial Credit**  
**3850 Marlette Drive**  
**York, SC 29745**

**(FOR FAST RESPONSE, PLEASE CALL OR FAX YOUR COMPLETED APPLICATION TO: 803-831-2339)**

SALES REPRESENTATIVE:
EQUIPMENT DESCRIPTION:
COST OF EQUIPMENT:

**PRACTICE INFORMATION**

LEGAL PRACTICE NAME:	BUSINESS TELE:	BUSINESS FAX:
BILLING ADDRESS:	CITY STATE ZIP COUNTY	YEARS IN BUSINESS: _____
EQUIPMENT ADDRESS IF DIFFERENT THAN ABOVE:	CITY STATE ZIP COUNTY	
(Check one only) CORPORATION: _____ PARTNERSHIP: _____ PROPRIETOR: _____ TAX ID#: _____		

**OWNERSHIP**

OWNER (FULL NAME):	BOARD LICENSE #:	% OF OWNERSHIP	HOME PH #
HOME ADDRESS: OWN ( ) RENT ( ) OTHER ( )	CITY	STATE	ZIP: SOCIAL SECURITY #:

Are you currently liable for any tax liens or ever filed for or declared bankruptcy? ( ) No ( ) Yes (If so explain on separate page and attach)

**OTHER OWNER**

OTHER OWNERS (FULL NAME):	BOARD LICENSE #:	% OF OWNERSHIP	HOME PH #
HOME ADDRESS: OWN ( ) RENT ( ) OTHER ( )	CITY	STATE	ZIP: SOCIAL SECURITY #:

Are you currently liable for any tax liens or ever filed for or declared bankruptcy? ( ) No ( ) Yes (If so explain on separate page and attach)

**BANK CREDIT INFORMATION**

NAME OF BANK	BANK CONTACT:	TELE #	ACCT. #:
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The undersigned individual(s) as principal(s) of and/or guarantor(s) for the applicant, authorizes Atlantic Commercial Credit Corp., its designee, assigns or potential assigns, to review his/her personal credit profile provided by national credit bureaus in considering this application and for the purpose of the update, renewal, or extension of credit to the applicant or the collection of any resultant accounts. A fax or photocopy of this authorization shall be valid as the original.

\_\_\_\_\_  
**SIGNED**

\_\_\_\_\_  
**SIGNED**