



MARLIN HEALTHCARE LEASE APPLICATION

Lease Application

MAY WE CONTACT LESSEE IF ADDITIONAL INFORMATION IS NEEDED? YES NO

FULL LEGAL BUSINESS NAME: _____

OWNER: _____ SOCIAL SECURITY NUMBER: _____

ADDRESS: _____

E-MAIL: _____ INTERNET ADDRESS: _____

PHONE: _____ FAX: _____ FEDERAL TAX ID: _____ YEARS IN BUSINESS: _____

NATURE OF BUSINESS: _____ YEARS OF OWNERSHIP: _____

STATE OF INCORPORATION/ORGANIZATION: _____ BUSINESS TYPE: CORP. LIMITED LIABILITY CORP. PARTNERSHIP PROPRIETORSHIP

PRACTICE INFORMATION

YEAR PRACTICE STARTED: _____ LICENSED STATE: _____

DATE OF LICENSE: _____ SPECIALTY: _____

The person(s) supplying the above information certifies to Marlin Leasing Corporation that it is true and correct. The Owners/Partners/Guarantors recognize that their individual credit histories may be a factor in the evaluation of the lease applicant and, thus, authorize Marlin Leasing Corporation or its designee to investigate their personal credit status. This includes obtaining and using their consumer credit reports from time to time in the credit evaluation and collection processes.

X _____

For information, call

888-479-9111 ext.



Healthcare Division
300 Fellowship Road
Mount Laurel, NJ 08054
888.479.9111, fax: 800.936.0147
www.marlinleasing.com

