

MEDICAL/DENTAL CREDIT APPLICATION

Please return by fax to:

Credit Department At 877-414-0615

Or call 877-414-0616

COMPANY

Full Legal Name		Operating As	
Partnership <input type="checkbox"/>		Corporation <input type="checkbox"/>	
		Profession	
Address Including Postal Code			
Phone () - () - () -	Fax () - () - () -	Cell () - () - () -	
Reason for Equipment Acquisition			

PERSONAL/PRINCIPAL INFORMATION

Full Name		Date of Birth (dd/mm/yy)	SIN #
Address		City/Province /	Postal Code
Home Phone () -		University Attended	
Years?			
Number of Years Private Practice years	Number of Years Non-Private Practice years	<input type="checkbox"/> Joint Lease? If yes, with Dr.	
Supplier	Phone () -	Accountant	Phone () -

BANK

Bank	Branch	How Long?
Contact	Phone () -	Account #

EQUIPMENT TO BE LEASED

Description including Make/Model etc.		
Cost \$	Term	Vendor
Representative	Phone () -	Fax () -
Address including postal Code		Website/E-mail

LEASING DETAILS

New Equipment	\$	<input type="checkbox"/> New Practice	<input type="checkbox"/> Leaseback
Used Equipment	\$	Is equipment clear of all encumbrances?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Computers	\$	If no, provide details:	
Furniture	\$		
Custom Cabinetry	\$		
Leasehold Improvements	\$	Delivery Date	

The undersigned certifies the above information to be true and correct. By signing below, I consent and authorize the following entities: Lease Link Canada Corp., Medi Credit a division of Lease Link Canada Corp., Lease Link Capital Corp., and Varion Capital Corp. (hereinafter, collectively known as Lease Link) and its representatives, at any time to obtain on an on-going basis, verify, use, communicate with and disclose to third parties (including credit reporting agencies, credit exchanges, leasing brokers, and credit grantors, on an on-going basis) any of my credit, financial, and personal information that Lease Link deems necessary to complete, service or enforce any lease, ancillary deed or transaction, including but not limited to assignments and securitizations.

You authorize us to collect, hold, exchange and disclose your personal information as requested in order to administer your contract & determine your insurance eligibility as required or permitted by law. You also authorize us to use your personal information for internal statistical analysis purposes.

If you would like to review your own personal information, correct or revise existing information, have any questions, concerns or comments regarding it's application please fax 1-780-414-0615 (Attn: Privacy Office) or mail #205, 10471 - 178St. Edmonton, AB T5S 1R5 Attn: Privacy Office.

Signature of Applicant:

Title:

Date:

X _____
