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3B MEDICAL INC

BLANKET LEASE APPLICATION

LESSEE FULL LEGAL COMPANY NAME

LESSEE COMPANY ADDRESS CITY COUNTY STATE ZIP

PHONE FAX CONTACT FEDERAL ID #

E-MAIL ADDRESS WEB-SITE ADDRESS

EQUIPMENT LOCATION CITY COUNTY STATE ZIP (IF DIFFERENT THAN ABOVE)

BUSINESS TYPE (Check one) TIME IN BUSINESS NATURE OF BUSINESS CORPORATION PROPRIETORSHIP PARTNERSHIP LIMITED LIABILITY CORPORATION Years in Business

PRINCIPAL(S) TITLE SOCIAL SECURITY No. HOME ADDRESS

1.

2.

BANK REFERENCES ACCT. No. ACCOUNT TYPE CONTACT PHONE (list all banks used for last 5 years)

1.

2.

TRADE REFERENCE ACCT. No. ACCOUNT TYPE CONTACT PHONE

1.

INSURANCE AGENT Name, Contact, and Phone No.

EQUIPMENT DESCRIPTION

VENDOR PHONE No. CONTACT

EQUIPMENT COST TERM OF LEASE

BANK AND TRADE RELEASE

I HEREBY AUTHORIZE OUR BANK AND TRADE REFERENCES TO RELEASE THE INFORMATION REQUESTED BY 3B MEDICAL, INC AND/OR ITS ASSIGNS OR AGENTS REGARDING OUR COMPANY'S ACCOUNTS WITH YOUR FIRM. I ALSO AUTHORIZE YOU TO OBTAIN PERSONAL CREDIT INFORMATION ON ALL PRINCIPALS AND OR GUARANTORS LISTED ABOVE, FROM ANY REPORTING AGENCY, USED BY 3B MEDICAL, INC AND/OR ITS ASSIGNS OR AGENTS. PLEASE RESPOND TO THEIR TELEPHONE REQUEST OR BY FAX IF YOU NEED WRITTEN PROOF OF THE REQUEST AND OUR RELEASE.

THIS IS YOUR WRITTEN AUTHORIZATION TO RELEASE THE INFORMATION REQUESTED.

BY: DATE:

BY: DATE:

PLEASE RETURN COMPLETED APPLICATION TO:

DESIREE THOMAS-GREENIDGE 863-226-6285 FAX: 863-226-6284 EXT 110