BRADFORD MEDICAL ASSOCIATES, INC.

Credit Application

BUSINESS NAME ____

BUSINESS ADDRESS ____
(STREET) (CITY) (STATE) (ZIP CODE)

WEB SITE ADDRESS____________________E-MAIL____________________

TELEPHONE ____________FAX__________ CONTACT ____________________

NATURE OF BUSINESS ____________________YRS. IN BUSINESS ______________

PROP. _____ CORP. _______ PARTNERSHIP _____ STATE __________ COUNTY________________

PRESIDENT/OWNER ______________________________% OF OWNERSHIP ________

HOME ADDRESS ____

SOCIAL SECURITY # ____________________TELEPHONE NUMBER______________

V.P./PARTNER ______________________________% OF OWNERSHIP _______

HOME ADDRESS ____

SOCIAL SECURITY #____________________TELEPHONE NUMBER ______________

BANK ______________________________ BRANCH ____________________

TELEPHONE ______________________________ ACCOUNT # ____________________

OFFICER ____________________CHECKING _______ LOAN _______SAVINGS ____________

TRADE REFERENCES ______________________________ PHONE # ______________

TRADE REFERENCES ______________________________PHONE # ______________

TRADE REFERENCES ______________________________PHONE # ______________

EQUIPMENT VENDOR ____________________ TELEPHONE ____________CONTACT ________

EQUIPMENT SELLING PRICE ____________ EQUIPMENT DESCRIPTION ____________________

By signing below, the undersigned, which is either a principal of the applicant or a personal guarantor of it's obligations, provides written instruction to Springs Financial Services Inc. or it's assigns authorizing review of his/her personal credit bureau. Such authorization shall extend to obtaining a credit file in considering this application for reviewing or collecting the resulting account. A Photostat or Facsimile copy of this authorization shall be valid as the original. By signature I affirm my identity as the individual identified in this application.

SIGNATURE ____________________________ DATE______________________

Equipment Leasing Provided By:

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Website: http://www.bradfordbilling.com