

Fax Completed Application to Dr. Edward R. Popick

Phone: (800) 526-5557 Fax: (561) 793-5311

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Company/Practice Information

LEGAL BUSINESS NAME:	
ADDRESS:	
CITY/STATE/ZIP:	
PHONE:	FAX:
EMAIL:	
YRS IN PRACTICE:	FEDERAL TAX ID#:
EQUIPMENT:	INVESTMENT PRICE:

Personal Information

NAME:	TITLE:	% OWNERSHIP:
HOME ADDRESS		
CITY/STATE/ZIP:		
HOME PHONE:	CELL:	
SOCIAL SECURITY #	PROFESSIONAL LICENSE #	
DATE OF BIRTH:	ANNUAL INCOME:	
DO YOU HAVE A	<input type="checkbox"/>	CHECKING ACCOUNT
	<input type="checkbox"/>	SAVINGS ACCOUNT
DO YOU	<input type="checkbox"/>	OWN YOUR HOME
	<input type="checkbox"/>	RENT YOUR HOME

Partner Information

NAME:	TITLE:	% OWNERSHIP:
HOME ADDRESS		
CITY/STATE/ZIP:		
HOME PHONE:	CELL:	
SOCIAL SECURITY #	PROFESSIONAL LICENSE #	
DATE OF BIRTH:	ANNUAL INCOME:	
DO YOU HAVE A	<input type="checkbox"/>	CHECKING ACCOUNT
	<input type="checkbox"/>	SAVINGS ACCOUNT
DO YOU	<input type="checkbox"/>	OWN YOUR HOME
	<input type="checkbox"/>	RENT YOUR HOME

Signature

Date

Signature

Date

By signing this application I/we hereby authorize the release of business and/or personal credit information to Innovative Healthcare Associates, LLC and/or its assigns for the purpose of investigating my/our credit for the purposes of obtaining lease financing. I/we certify that the information given herein is true and correct. A photo static and/or facsimile copy of this authorization shall be valid as the original. To help the government fight the funding of terrorism and money laundering activities, Federal law requires all financial institutions to obtain, verify and record information that identifies each person who opens an account. What this means for you: When you open an account, we will ask for your name, address, date of birth and other information that will allow us to identify you. We may also ask to see your driver's license or other identifying documents.