



**creditmedical**  
CORPORATION

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# CREDIT APPLICATION

Applicant's Information					Application Reference #:	
Optional : Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms. <input type="checkbox"/>		First Name:			Last Name:	
Home Phone:		Business Phone:		Fax:		Contact before faxing? <input type="checkbox"/> Yes <input type="checkbox"/> No
Present Address:			Apt:	City:		Province: Postal Code:
How long at this address? yrs.		Rent: <input type="checkbox"/> Own: <input type="checkbox"/>	Monthly Rent or Mortgage: \$	S.I.N number:		Driver's License Number + Prov. Date of Birth: M / D / YR
Present Employer (Company Name):			Occupation:		Contact Name:	Contact Phone: Length of Employment: yrs.
Employment Status: Full Time: <input type="checkbox"/> Part time: <input type="checkbox"/> Retired: <input type="checkbox"/> Self-Employed: <input type="checkbox"/> Student: <input type="checkbox"/>						
Gross Annual Income:\$ yr.		Net Annual Income:\$ yr.		Other Income:		Specify Amount:\$
Bank:			Institution #:		Branch #: Account #:	
Credit Card:		Account Number:		Expiry:		Credit Card: Account Number: Expiry:
Have you ever declared bankruptcy? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when: Email:						
Cosigner Information (If applicable)					Relation to applicant:	
Optional : Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms. <input type="checkbox"/>		First Name:			Last Name:	
Home Phone:		Business Phone:		Fax:		Contact before faxing? <input type="checkbox"/> Yes <input type="checkbox"/> No
Present Address:			Apt:	City:		Province: Postal Code:
How long at this address? yrs.		Rent: <input type="checkbox"/> Own: <input type="checkbox"/>	Monthly Rent or Mortgage: \$	S.I.N number:		Driver's License Number + Prov. Date of Birth: M / D / YR
Present Employer (Company Name):			Occupation:		Contact Name:	Contact Phone: Length of Employment: yrs.
Employment Status: Full Time: <input type="checkbox"/> Part time: <input type="checkbox"/> Retired: <input type="checkbox"/> Self-Employed: <input type="checkbox"/> Student: <input type="checkbox"/>						
Gross Annual Income:\$ yr.		Net Annual Income:\$ yr.		Other Income:		Specify Amount:\$
Bank:			Institution #:		Branch #: Account #:	
Credit Card:		Account Number:		Expiry:		Credit Card: Account Number: Expiry:
Have you ever declared bankruptcy? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when: Email:						

**Terms and Conditions:** I understand that the information I provide is for the purpose of obtaining credit from Credit Medical Corporation and is warranted to be true and complete. I hereby authorize and consent to the receipt and exchange of information about me by Credit Medical Corporation and its affiliates from time to time as Credit Medical Corporation may deem appropriate, including the making by Credit Medical Corporation and its affiliates of whatever credit investigations and/or employment and income references as Credit Medical Corporation may deem appropriate from time to time, and to sharing or exchange of reports and information with credit reporting agencies, or any company with whom I have or may propose to have a financial relationship.

Credit Medical Corporation will contact your doctor's office or medical treatment facility upon approval. If you require an immediate answer or have special instructions please use the space provided here: \_\_\_\_\_

\$ \_\_\_\_\_ Amount of Financing Required: \_\_\_\_\_ Approximate Date of Procedure: \_\_\_\_\_ **Loan Term:** 6 mon.  1 yr.  2 yr.   
3 yr.  4 yr.

Patient Name: \_\_\_\_\_

Medical Treatment Centre or Doctor's Office/Name: \_\_\_\_\_ Type of Procedure: \_\_\_\_\_

\_\_\_\_\_  
**Signature of Applicant** Date \_\_\_\_\_ **Signature of Co-signer/Guarantor** Date \_\_\_\_\_  
(only if applicable)