

"LEASE TO OWN" APPLICATION

FAX: 800-637-2543
PHONE: 1-800-336-2776

INTERNAL USE

Date _____ Time _____

VENDER INFORMATION

Vendor's Name Eagle Equipment		Contact
Telephone # 800-336-2776	Fax # 800-637-2543	Email Address:
Street 4810 Clover Rd	City Greensboro	State NC
		Zip

PAYMENT PLAN

Term in Months	Factor Used	Lease payment \$	Security Deposit \$
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EQUIPMENT TO BE LEASED (Attach separate list if necessary.)

Description (Include make, model & serial #'s and any attachments)	Equipment Cost: \$
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LESSEE (Complete legal name of entity. If a corporation, use EXACT registered corporate name.)

Company	DBA	FED I.D. #
Address	City	County
	State	Zip
Telephone # ()	Fax # ()	Email Address
Nature of Business	Contact Person ___ Mr. ___ Mrs. ___ Ms.	# of yrs in business (Present Ownership)
Type of Business ___ Proprietorship** ___ State ___ Corp. (Registered State ___) ___ Partnership ___ Non-Profit(Registered State ___)		

**do you have a business license? ___ yes ___ no

PERSONAL INFORMATION ON OFFICERS, PARTNERS OR GUARANTORS

Name	Title	%Ownership	Social Security #
Home Address	City	State	Zip
			Home Phone Number ()

TRADE REFERENCES - TWO YEAR HISTORY

Name of Supplier	City/State	Telephone ()	Contact Person
Name of Supplier	City/State	Telephone ()	Contact Person
Name of Supplier	City/State	Telephone ()	Contact Person

COMPANY BANK REFERENCES - TWO YEAR HISTORY

Name of Bank / Branch	City/State	Chkg. Acct. #	Telephone ()	Contact Officer
		Loan Acct. #		
Name of Bank / Branch	City/State	Chkg. Acct. #	Telephone ()	Contact Officer
		Loan Acct. #		

By signing below, the undersigned individual as principal of and/or guarantor for the applicant, authorizes Eagle Equipment (or Broker/Lessor), to review his/her personal credit profile provided by national credit bureaus in considering this Application and for the purpose of the update renewal, or extension of credit to the Applicant or the collection of any resultant accounts. A copy of this authorization shall be valid as original.

Signature _____ Print Name _____ Date _____