



PO Box 8107
Seminole, FL 33775
877-843-6464
FAX 727-319-5695

CREDIT APPLICATION
COMPLETE IN FULL

Company Name: _____ Tel: _____
Address: _____ Fax: _____
City: _____ State: _____ Zip: _____
Corporation: ____ Partnership: ____ Proprietorship: ____ Other: ____ Year Established: ____
Sales Tax Number: _____ Federal Employer ID#: _____

Principals or Officers of the Company:

Name: _____ Title: _____
Name: _____ Title: _____
Name: _____ Title: _____

TRADE REFERENCES

Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Tel: _____ Fax: _____
Acct Number: _____

Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Tel: _____ Fax: _____
Acct Number: _____

Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Tel: _____ Fax: _____
Acct: _____

Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Tel: _____ Fax: _____
Acct Number: _____

BANK REFERENCES

Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Tel: _____ Fax: _____
Acct: _____

Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Tel: _____ Fax: _____
Acct: _____

Lifestyle Mobility Aids is hereby authorized to obtain credit history information from the above references for the purpose of reviewing for a dealership.

Signature: _____ Title: _____

Print Name: _____ Date: _____

PERSONAL GUARANTEE

I, _____, hereby personally guarantee any and all credit extended to my company. I will be personally responsible and liable for all balances due, including costs of collection, should that become necessary.

Signature: _____ Print Name: _____
Home Address: _____ Home Phone #: _____ Date: _____