11433 CRONRIDGE DRIVE, SUITE F
OWINGS MILLS, MD 21117
443.796.7333 • 800.733.5529 • FAX 443.796.7200
FAX TO: TOM MYERS 443-213-1592
or EMAIL TO: tmyers@madisoncapital.com

AHR AVIATION

MADISON CAPITAL
EQUIPMENT & VEHICLE FINANCING

DATE:

LEASE CREDIT APPLICATION

NAME OF ORGANIZATION:		COUNTY WHERE PROPERTY WILL BE LOCATED:	
ADDRESS:	CITY:	STATE:	ZIP:
PHONE:	DATE ESTABLISHED:	# OF CLIENTS SERVED:	INCORPORATED: ☐ YES ☐ NO
WHERE DOES FUNDING FOR THE ORGANIZATION ORIGINATE?	% GOVERNMENT SUPPORT	# OF EMPLOYEES:	
CURRENT YEAR BUDGET:	NEXT YEAR BUDGET:	STATE OF INCORP:	GEOGRAPHIC TERRITORY:
PERSON AUTHORIZED TO SIGN LEASE DOCUMENTS:	POSITION:	$ AUTHORITY:	
ANY RESTRICTIONS WITH REGARD TO LEASING?			
IS LEASE SUBJECT TO ANNUAL APPROPRIATIONS?			
AT WHAT $ LEVEL ARE YOU SUBJECT TO A BOARD OF DIRECTORS IN THE DECISION MAKING PROCESS?			
CONTACT PERSON:	PHONE:	FAX:	EMAIL:

BANK REFERENCE

NAME OF BANK:	PHONE:	PERSON TO CONTACT:
CHECKING ACCT #	SAVINGS ACCT #	LOAN ACCT:
NAME OF BANK:	PHONE:	PERSON TO CONTACT:
CHECKING ACCT #	SAVINGS ACCT #	LOAN ACCT:

CREDIT REFERENCE

NAME OF COMPANY:		ACCOUNT #		PHONE:	
NAME OF COMPANY:		ACCOUNT #		PHONE:	
NAME OF COMPANY:		ACCOUNT #		PHONE:	
CURRENT LEASE OBLIGATION ☐YES ☐NO	NAME OF CO OR BANK:		PHONE:		ACCOUNT:
DO YOU RENT YOUR OFFICE SPACE? ☐ YES ☐ NO	NAME OF LANDLORD:		PHONE:		

INSURANCE INFORMATION

NAME OF INSURANCE AGENT:		PHONE:	
ADDRESS:	CITY:	STATE:	ZIP:

EQUIPMENT VENDOR INFORMATION

NAME:	CONTACT PERSON:
ADDRESS:	PHONE:

QTY	NEW/USED	EQUIPMENT TO BE LEASED	PRICE WITHOUT TAX

DESIRED TERM: ☐ 12 MONTHS ☐ 24 MONTHS ☐ 36 MONTHS ☐ 48 MONTHS ☐ 60 MONTHS | RESIDUAL ☐ NO RESIDUAL ☐

RELEASE

TO WHOM IT MAY CONCERN:

THIS WILL BE YOUR AUTHORITY AND MY REQUEST FOR YOU TO RELEASE TO MADISON CAPITAL, LLC ANY INFORMATION THEY MAY REQUEST CONCERNING CREDIT STANDING WITH YOUR COMPANY AND/OR MONEY ON DEPOSIT. I HEREBY FURTHER AUTHORIZE MADISON CAPITAL, LLC TO OBTAIN ANY PERSONAL CREDIT BUREAU REPORTS (IF APPLICABLE) AND UTILIZE PHOTOCOPIES OF THIS RELEASE IN CONJUNCTION WITH THE LEASE APPLICATION PROCESS.

FOR (COMPANY NAME): _____

BY (NAME OF OFFICER): _____ TITLE: _____

SIGNATURE: _____ DATE: _____