

## FRANCHISE APPLICATION

First Name: \_\_\_\_\_ Middle: \_\_\_\_\_ Last Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

E-Mail: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Marital Status:  Single  Married  Divorced

Will you have other owners/partners?  Yes  No

Have you ever been convicted of a felony?  Yes  No

Are you or anyone in your immediate family a partner or owner (partial or otherwise), or employee of a medical staffing company?  Yes  No

Are you or anyone in your immediate family employed by a medical staffing company?  Yes  No

Do you have financing to open a Encore Medical Staffing franchise?  Yes  No

Are you a U. S. Citizen?  Yes  No

I understand that the acceptance of this franchise application does not constitute the grant of a franchise. I understand that **Encore Medical Staffing, Inc** grants franchises only by executing written franchise agreements. By signing below, I authorize **Encore Medical Staffing, Inc** and its assigns to start an investigative consumer report (including information as to my character, general reputation, personal characteristics and mode of living) and credit investigation based on the information voluntarily provided by me and warrant that all information provided is true and accurate. I understand that I have a right to request that **Encore Medical Staffing, Inc** make a complete and accurate disclosure of the nature and scope of such investigation. **Encore Medical Staffing, Inc** may obtain my credit report in connection with this application. This is my authorization to credit reporting agencies, banks, creditors, and suppliers to release to **Encore Medical Staffing, Inc** and to **Encore Medical Staffing, Inc** to release to such parties, all information requested regarding my depository, loan, or other credit information including, without limitation, financial information, by telephone or in writing as part of the normal credit evaluation process. I understand that **Encore Medical Staffing, Inc** may, at any time, require that I sign an updated application or provide updated information.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Please Mail to: 107 Station Street, Lyman, SC 29365

Please Fax to: 1-800-915-0559 or Email to: [corporate@encoremedicalstaffing.com](mailto:corporate@encoremedicalstaffing.com)