



205 W. Bement Street, P. O. Box 626, Bryan, OH 43506  
Phone: 419.636.6304 / 800.322.8546 / Fax: 419.636.7916

## Home Phototherapy Financing Program Application

• **Name / Address of Applicant:**

Name:		Social Security Number:
Address:		
City:	State:	ZIP:
Phone:	Cell Phone:	

• **Employment:**

Employer:	Job Title:	
Address:		
City:	State:	ZIP:
Phone:	Date From:	Date To:

• **Please list at least one family member not currently living with you:**

Name:		
Address:	State:	ZIP:
Phone:	Cell Phone:	

• **Financing Requested:**

Total Amount of Purchase:	Item:	
Deposit Amount (At least 50% deposit required to ship product):	Date of Purchase:	
Balance to be Financed:	# of Months:	Finance Fee:
Monthly Payment Amount:	Monthly Payment Date ( 15th or 30 <sup>th</sup> ):	
Credit Card Number:	V code:	Expiration Date:

I hereby certify that the information contained herein is complete and accurate. This information has been furnished with the understanding that it is to be used to determine the amount and conditions of the credit to be extended to me by Daavlin for purchase of a prescription home phototherapy device. I understand that once approved, my credit card will be charged for one payment per month until the balance is paid. I may pay my balance in full at any time without penalty.

\_\_\_\_\_  
*Signature*

\_\_\_\_\_  
*Date*