First Choice medical staffing, inc.

" YOUR 24/7 NURSE STAFFING PARTNER"

FRANCHISE APPLICATION

First Name: _____Middle Name: _____Last Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Secondary Address: _____

City: _____ State: _____ Zip Code: _____

Social Security #: _____ Date of Birth: _____

E-Mail: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Are you married? ___ Yes ___ No – if yes, spouse's name _____

Will you have other owners/partners? ____ Yes ____ No -if yes, other owners/partners must complete individual application.

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) of a medical staffing company? ____ Yes ____ No

Are you or anyone in your immediate family employed by a medical staffing company? ____ Yes ____No

I understand that if financing is required to open my First Choice Medical Staffing franchise, it is my sole responsibility to obtain the financing ____ 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 First Choice Medical Staffing, Inc grants franchises only by executing written franchise agreements. By signing below, I authorize First Choice 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 First Choice Medical Staffing, Inc make a complete and accurate disclosure of the nature and scope of such investigation. First Choice 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 First Choice Medical Staffing, Inc and to First Choice 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 First Choice Medical Staffing, Inc may, at any time, require that I sign an updated application or provide updated information.

Signature: _____ Printed Name: _____ Date: _____

Please mail application to: 131 Court St, Ville Platte, LA 70586 or fax to (337) 363-6783