

BUYER'S CHECKLIST

- Practice Evaluation Profile (required)
- Tax returns (2 years; full copies, personal and professional)
(3 years tax returns required if transaction is over \$500,000)
- Copy of the draft purchase and sale agreement(s) (if available)
- Curriculum vitae
- Copy of professional license
- General summary of transition
- Production Reports (Last 12 months)

BUYER'S INFORMATION

^New organization name: _____ ^S.S. # _____ ^Tax ID #: _____
 New organization type: _____ License # & states: _____
 State of organization: _____ Year graduated: _____ School: _____
 Date organization formed: _____ E-mail: _____ ^Date of birth: _____
 ^Buyer's name: _____ Are you a US citizen? Yes No If no, INS status: _____
 ^Home address: _____ Practice broker: _____
 ^City, state, zip: _____ Practice broker phone: (_____) _____
 Home phone: (_____) _____ Attorney: _____
 Cell phone: (_____) _____ Attorney phone: (_____) _____
 Office phone: (_____) _____ Accountant: _____
 Accountant phone: (_____) _____

^For individual applicants: Federal law requires us to collect and verify your name, physical address, social security number, and date of birth.
 ^^For organized business applicants: Federal law requires us to collect and verify the business name, physical address, and tax identification number.

FINANCING NEEDS

Total amount requested \$ Practice Working Capital Equipment/Improvements Total
 Seller financing amount, if any \$ _____ Account Receivables included? Yes No Closing date: _____

BUYER PROFESSIONAL INFORMATION

Monthly personal production as an associate or in your current practice:
 Average number patients seen per day _____ Days worked per week _____ % HMO _____ PPO _____ Fee for Service _____
 Pay Structure: Salary _____ Production % _____ Per day production: _____ Per month production: _____
 What is your weekly schedule? (ex. 4 days a week: 8 hrs a day) _____ Mon. _____ Tues. _____ Weds. _____ Thurs. _____ Fri. _____ Sat.
 Compensation 200__ \$ _____ 200__ \$ _____ 200__ \$ _____
 How many practice(s) are you currently working in? _____ Have you initiated the insurance credentialing process? Yes No
 Do you have a non-compete contract? Yes No If yes, _____ miles _____ years
 Do you currently own a practice? Yes No When did you buy/start-up your present practice? _____
 If yes, is your current practice free of liens? Yes No Lien holders: _____ Amt. of Debt: _____
 If you own a practice, will the locations be merged? Yes No If yes, what is the distance between the two locations? _____
 If no, how will you divide your time between the two locations? _____
 Will you hire an associate? Yes No If yes, what will be the compensation? _____
 Will you incorporate or change the name of the practice after the acquisition? Yes No Have you met the staff? Yes No
 Have you visited the practice? Yes No Has the lease been negotiated? Yes No Terms: _____
 Have you had any actions against your license? Yes No Will you need to relocate after the transition? Yes No
 If yes, what will you do with the proceeds from the sale of your home and/or practice? _____
 Have you ever filed bankruptcy? No Yes; If yes, when? _____ Please attach a written explanation.
 Are you involved in any litigation at this time? No Yes; If yes, please attach a written explanation.

By signing below, I certify that I am authorized to submit this application as Applicant / Co-applicant or on behalf of the Applicant / Co-applicant and that all of the information and documents provided in connection with this application are true, accurate and complete. I authorize Bank of America, N.A. / Banc of America Practice Solutions, Inc. to obtain and verify consumer reports, business reports and other information from, and to report such information to, others about me and Applicant / Co-Applicant for purposes of reviewing this application and servicing an approved loan made based on this application, and that the loan will be used only for business purposes.

NOTICE The Ohio laws against discrimination require that all creditors make credit equally available to all creditworthy customers, and that credit reporting agencies maintain separate credit histories on each individual upon request. The Ohio Civil Service Commission administers compliance with this law.

Applicant's Signature X _____ Date _____
 Co-applicant's Signature X _____ Date _____

*Subject to credit approval and loan amounts are subject to creditworthiness. Some restrictions may apply.

Assets		(omit cents)	Liabilities		(omit cents)
Cash on Hand			Accounts Payable		\$ _____
Personal Account.....	\$ _____		Notes Payable to Banks and Others.....		\$ _____
Business Account	\$ _____		(Describe in Section 2)		
IRA or Other Retirement Account(s)	\$ _____		Installment Account (Auto).....		\$ _____
Accounts & Notes Receivable.....	\$ _____		Mo. Payments \$ _____		
Life Insurance - Cash Surrender Value	\$ _____		Installment Account (Student Loans).....		\$ _____
Stocks and Bonds	\$ _____		Mo. Payments \$ _____		
Real Estate	\$ _____		Loan on Life Insurance.....		\$ _____
(Describe in Section 3)			Mortgages on Real Estate.....		\$ _____
Automobile - Present Value	\$ _____		(Describe in Section 3)		
Other Personal Property	\$ _____		Unpaid Taxes.....		\$ _____
(Describe in Section 4)			(Describe in Section 5)		
Other Assets.....	\$ _____		Other Liabilities.....		\$ _____
(Describe in Section 4)			(Describe in Section 6)		
			Total Assets		\$ _____
			Total Liabilities		\$ _____
			Total Net Worth		\$ _____

Section 1: Source of Income		Contingent Liabilities	
Salary	\$ _____	As Endorser of Co-Maker	\$ _____
Net Investment Income	\$ _____	Legal Claims & Judgments	\$ _____
Real Estate Income	\$ _____	Provision for Federal Income Tax	\$ _____
Other Income (Describe Below)**	\$ _____	Other Special Debt	\$ _____

Description of Other Income in Section 1

**Alimony, child support or separate maintenance income need not be revealed if you do not wish to have it considered as a basis for repaying this obligation.

Section 2: Notes Payable to Banks and Others					
Name of Institution / Note Holder	Original Balance	Current Balance	Payment Amount	Frequency (monthly, etc.)	How Secured or Endorsed Type of Collateral

_____ Applicant's Initial

_____ Co-Applicant's Initial (if applicable)

Section 3: Real Estate Owned	List each parcel separately. Use attachment if necessary. Each attachment must be identified as a part of this statement and signed.		
	Property A	Property B	Property C
Type of Property (Residence, Rental, etc.)			
Address			
Date Purchased			
Purchase Price			
Present Market Value			
Lien Holder/Bank			
Mortgage Balance			
Monthly Payment (Principal & Interest)			

Section 4: Other Personal Property and Other Assets

Section 5: Unpaid Taxes Describe in detail as to type, to whom payable, when due, and to what property, if any, a tax lien attaches.

Section 6: Other Liabilities (Describe in detail)

Statement of Financial Condition Consent & Disclosure

I authorize Bank of America, N.A. / Banc of America Practice Solutions, Inc.™ to make inquiries as necessary to verify the accuracy of the statements made and to determine my creditworthiness. I certify the above and the statements contained in the attachments are true and accurate as of the stated date(s). These statements are made for the purpose of either obtaining a loan or guaranteeing a loan.

Applicant (print name): _____ Co-Applicant (print name): _____
 Signature _____ Date _____ Signature _____ Date _____



DEBT SERVICE SCHEDULE

Borrower's Name: _____

LOAN PAYMENTS (and Lease Payments not included in cash expenses)

	Payable to Whom	Collateral	Original Date	Original Amount	Current Balance	Principal Due Within 1 Year	Principal Due Beyond 1 Year	Accrued Interest	Interest Rate	Monthly Payment	Due Date(s) of Payments
1.			/ /	\$	\$	\$	\$	\$	%	\$	
2.			/ /	\$	\$	\$	\$	\$	%	\$	
3.			/ /	\$	\$	\$	\$	\$	%	\$	
4.			/ /	\$	\$	\$	\$	\$	%	\$	
5.			/ /	\$	\$	\$	\$	\$	%	\$	
6.			/ /	\$	\$	\$	\$	\$	%	\$	
7.			/ /	\$	\$	\$	\$	\$	%	\$	
8.			/ /	\$	\$	\$	\$	\$	%	\$	
9.			/ /	\$	\$	\$	\$	\$	%	\$	
10.			/ /	\$	\$	\$	\$	\$	%	\$	
11.			/ /	\$	\$	\$	\$	\$	%	\$	
12.			/ /	\$	\$	\$	\$	\$	%	\$	
13.			/ /	\$	\$	\$	\$	\$	%	\$	
14.			/ /	\$	\$	\$	\$	\$	%	\$	
15.			/ /	\$	\$	\$	\$	\$	%	\$	



Practice Acquisition Application*

Practice Evaluation Profile

Send all information to:
600 N. Cleveland Ave. • Westerville, OH 43082
800-360-0669 • Fax 800-209-1922

SELLER'S CHECKLIST

- | | |
|--|--|
| <input type="checkbox"/> Practice Evaluation Profile | <input type="checkbox"/> List of equipment |
| <input type="checkbox"/> Current year profit & loss (within 6 months (if 3 or more months into new business year) | <input type="checkbox"/> Procedure Breakdown |
| <input type="checkbox"/> Tax returns (2 years; include all expense and depreciation schedules)*
(3 years tax returns required if transaction is over \$500,000) | <input type="checkbox"/> Production by Provider Reports
(If multiple providers) |

SELLER'S INFORMATION

Seller's name: _____ Is the staff aware of the sale? Yes No
 Practice name: _____ Reason for sale of practice? _____
 Office address: _____ Will seller remain after the sale? Yes No
 City, state, zip: _____ If yes, how many months _____
 Office phone: (_____) _____ Compensation Structure _____
 How many days per week _____

PRACTICE TRANSITION DATA

Seller has been at location for how long? _____ years Year seller acquired practice: _____
 Practice has been in existence for how long? _____
 Are there any lien holders? Yes No If yes, please complete attached Debt Service Schedule.
 Does the seller own any other practices? Yes No If yes, distance between practices? _____
 Which practice will be sold (name & address)? _____
 If seller's practice is a specialty practice, please explain: _____
 Types of procedures currently referred out _____
 Does the practice have an associate? Yes # _____ No If yes, percentage of gross sales from associate(s) production? _____
 Will associate be retained? Yes No Does associate have a contract? Yes No
 Does the practice have a hygienist? Yes # _____ No How many months/weeks is the practice booked? _____
 Collection sources last 12 months

Office pmt./insurance

% Medicaid

% Capitation

 Main Office hours: Mon. _____ Tues. _____ Wed. _____ Thur. _____ Fri. _____ Sat. _____ Sun. _____

LEASE INFORMATION

Monthly rent \$ _____ Original lease term (yrs) _____ Lease expiration date _____
 Renewal option Yes No # years _____ Purchase option Yes No Date _____
 Lease renewal amount/month \$ _____ Purchase option amount \$ _____ Can this lease be assigned? Yes No
 Landlord Name _____ Landlord Phone # _____

BUILDING INFORMATION

Is the building for sale? Yes No If yes, what is the purchase price? \$ _____ Seller Financing Amount? \$ _____
 Total sq. ft. of building _____ Total number of floors _____ Building Type: Free Standing Condominium Cooperative
 Building Age _____ Does the practice occupy at least 51% of the building? Yes No Total number of tenants _____
 Total operatories plumbed _____ # equipped? _____ # doctor operatories? _____ # hygiene rooms? _____ R/L Handed _____
 Condition of equipment: Excellent Good Poor Average age of equipment _____ Is the office computerized? Yes No
 Does the practice need new equipment Yes No If yes, explain _____ Software _____
 Does the practice need leasehold improvements Yes No If yes, explain _____

PRACTICE PERFORMANCE

Procedure	% of Production	Procedure	% of Production	Number of active patient records
Hygiene	_____ %	Orthodontics	_____ %	Total patient records
Restorative	_____ %	Oral Surgery	_____ %	Average age of patients
Crown & Bridge	_____ %	Other	_____ %	New Patients Per Month
Endodontics	_____ %	Other	_____ %	Source
Periodontics	_____ %	Other	_____ %	How is seller's practice currently promoted (i.e. yellow pages, TV, etc.)?
Prosthodontics	_____ %	Other	_____ %	_____

OFFICE STAFF INFORMATION

Position	#	Days/Week	Hire Date	Is seller related to any office staff? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain:
Office Manager	_____	_____	_____	
Assistant	_____	_____	_____	
Associate	_____	_____	_____	
Hygienist	_____	_____	_____	
_____	_____	_____	_____	



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4.			/ /	\$	\$	\$	\$	\$	%	\$	
5.			/ /	\$	\$	\$	\$	\$	%	\$	
6.			/ /	\$	\$	\$	\$	\$	%	\$	
7.			/ /	\$	\$	\$	\$	\$	%	\$	
8.			/ /	\$	\$	\$	\$	\$	%	\$	
9.			/ /	\$	\$	\$	\$	\$	%	\$	
10.			/ /	\$	\$	\$	\$	\$	%	\$	
11.			/ /	\$	\$	\$	\$	\$	%	\$	
12.			/ /	\$	\$	\$	\$	\$	%	\$	
13.			/ /	\$	\$	\$	\$	\$	%	\$	
14.			/ /	\$	\$	\$	\$	\$	%	\$	
15.			/ /	\$	\$	\$	\$	\$	%	\$	