

MEDICAL INCORPORATION QUESTIONNAIRE
(IF RESPONSES ARE HANDWRITTEN, PLEASE USE INK)

Name of Owner: _____

Address: _____

Phone Numbers: Home: _____

Work: _____

Mobile: _____

NC Medical Board License #: _____

E-Mail Address: _____

Social Security #: _____

% of Ownership: _____

Cash/Property Contribution: _____

Name of Owner: _____

Address: _____

Phone Numbers: Home: _____

Work: _____

Mobile: _____

E-Mail Address: _____

Social Security #: _____

% of Ownership: _____

Cash/Property Contribution: _____

(If there are more than two owners, please attach additional sheet(s))

Name of Corporation: _____

Alternate Name: _____

Are you currently operating this business in another form? (Sole proprietor, etc.) _____

Fax number of Corporation: _____ Phone Number: _____

Registered Agent (*person who will receive official correspondence regarding company*):

Registered Office Address (business address for Registered Agent): _____

Estimate highest number of employees in first year: _____

Bank corporation will use: _____

Name of Accountant: _____

Name of Officers: President: _____ Secretary: _____

Treasurer: _____

TODD A. STEWART, P.A.

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