### Franchise Request Form

**Please complete the form below and submit along with your evaluation fee of $850 USD.**

**Applicant Information**

* Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Company/Clinic Name (if applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Country/City of Operation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Professional Background**

* Occupation/Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Years of Experience in Healthcare: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Medical or Business Licenses Held: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Franchise Interest**

* Desired Franchise Type (e.g., Dr. Slim™, Dr. Face™, etc.): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* New Clinic or Upgrade Existing Facility? (select one): [ ] New [ ] Upgrade
* Preferred Location(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Proposed Opening Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Business Readiness**

* Available Start-Up Capital: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Willingness to Follow Premium Doctors Protocols: [ ] Yes [ ] No
* Team or Personnel Already in Place: [ ] Yes [ ] No

**Declaration & Agreement** I hereby declare that the information provided above is accurate to the best of my knowledge. I understand that the evaluation fee is non-refundable and submission of this form does not guarantee franchise approval. I agree to abide by Premium Doctors’ ethical, branding, and operational standards should I be selected.

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

Please email the completed form and payment receipt to: [**franchise@premiumdoctors.org**](mailto:franchise@premiumdoctors.org)