Return completed form to Healthcare Realty:

EMAIL lkilbourne@healthcarerealty.com

MAIL 510 North Elam Avenue, Suite 110
Greensboro, North Carolina 27403

HEALTHCARE REALTY

Tenant Information

Contact

OFFICE

Tenant name: ______________________________

Building address: ______________________________ Suite #: ________

Phone: ____________ Back line: ____________ Fax: ____________

Email: ______________________________ Tenant cell number: ____________

EXECUTIVE CONTACT

Name: ______________________________ Title: ____________

Phone: ____________ Alt. phone: ____________ Email: ____________

DAY-TO-DAY CONTACT

Name: ______________________________ Title: ____________

Phone: ____________ Alt. phone: ____________ Email: ____________

SURVEY CONTACT

Name: ______________________________ Email: ____________

Office information

OFFICE HOURS

M ______-______ T ______-______ W ______-______ TH ______-______ F ______-______

SAT ______-______ SUN ______-______ Lunch hours ______-______

EXTRA HOLIDAYS *(Dates office will be closed aside from New Year's Day, Memorial Day, Independence Day, Labor Day, Thanksgiving Day, Christmas Day)*

____

PERSONNEL

Tenant specialties: ______________________________

Number of personnel Physicians: ________ Employees: ________ Patients/Clients: ________ /day (approximate)

Is there a subtenant in your suite? Yes No **If yes, list name of subtenant:** ____________

Billing

BILLING ADDRESS: ______________________________

ACCOUNTS PAYABLE CONTACT Name: ______________________________ Title: ____________

Email: ______________________________ Phone: ____________

Directory listing & tenant signage

Provide how your business should be listed on the building directory and suite sign.

BUSINESS

Business name: ________________________________ Suite # __________

PHYSICIANS

Last name:	First name:	MI (optional)	Credentials	Suite #

Access cards/keys

Tenant will be provided with the requested number of cards/keys, if reasonable. Additional cards/keys are available upon request for a fee.

Total number requested: _____ **Access cards** _____ **Keys** _____ **Mailbox keys**

EMPLOYEES WITH ACCESS CARDS/KEYS

Name:	Phone:	Card	Key	Mail

In case of emergency

EMERGENCY CONTACTS

Name:	Cell phone:	Email

Is there an alarm in your suite? Yes No **If applicable, provide code:** ____________________

Has someone been designated to check suite doors/lights at end of business day? Yes No

PERSONS AUTHORIZED TO ENTER SUITE

List all persons authorized to enter your suite should they require assistance from Healthcare Realty. Attach page for more names.

______________________ ______________________

______________________ ______________________

______________________ ______________________

AUTHORIZED BY:

Signature ________________________________ **Date** __________

(Electronic signature represented by blue type)

Name (print) ____________________ **Title** ____________________

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