Return completed form to Healthcare Realty:

FAX 303.980.0296

EMAIL tpelz@healthcarerealty.com

MAIL 11700 West Second Place, Suite 265
Lakewood, Colorado 80228

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** _____

Click to email form