Tenant Information Update

Changes to contact, billing and emergency 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: _____

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** _____