

Tenant Information

Return completed form to Healthcare Realty:

EMAIL scastrejon@healthcarerealty.com

MAIL 5701 North Portland Avenue, Suite 110
Oklahoma City, OK 73112

Contacts

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: _____

CERTIFICATE OF INSURANCE (COI) CONTACT

Name: _____ Title: _____

Phone: _____ Alt. phone: _____ 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: _____

Phone: _____ Alt. phone: _____ Email: _____

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.

Tenant Center access

Healthcare Realty offers office management shortcuts on the Tenant Center. Save time with automated rent payments, online service requests and more.

CONTACT	ACCESS	CONTACT	ACCESS
Executive Contact		Accounts Payable Contact	
Day-to-Day Contact		Emergency Contact #1	
Survey Contact		Emergency Contact #2	
COI Contact		Emergency Contact #3	

OTHER PERSON(S) THAT REQUIRE ACCESS

Name: _____ Title: _____

Phone: _____ Alt. phone: _____ Email: _____

Name: _____ Title: _____

Phone: _____ Alt. phone: _____ Email: _____

Name: _____ Title: _____

Phone: _____ Alt. phone: _____ Email: _____

AUTHORIZED BY:

Signature _____ **Date** _____
(Electronic signature represented by blue type)

Name (print) _____ **Title** _____

