

Return completed form to Healthcare Realty:
FAX 773.248.6203
EMAIL sprado@healthcarerealty.com
MAIL 3000 North Halsted, Suite 725
Chicago, Illinois 60657

Tenant name: _____
Building address: _____ Suite #: _____
Phone: _____ Fax: _____ Requestor's email: _____

Request details

1	RECIPIENT			
	Name: _____ Title: _____ Phone: _____ Email: _____			
2	DOOR LOCATION	RE-KEY DOOR	INSTALL LOCK	# OF KEY COPIES
	Suite entrance			_____
	Restroom			_____
	Mailbox			_____
	Other: _____			_____
	Other: _____			_____
	Other: _____			_____

We acknowledge and agree a locksmith will be required for lock service and for key copies if a copy-ready key is not available. All charges by the locksmith shall be charged back to the tenant's account.

AUTHORIZED BY:

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

Name (print) _____ **Title** _____

..... **OFFICE USE ONLY**

Authorized signature confirmed by: _____ Charges processed on: ____ / ____ / ____ by: _____
Initials Initials

