

## *Recipient Hospital Information Form*

<b>BASIC INFORMATION</b>	
<b>Hospital Name:</b>	
<b>Hospital Abbreviations / Nicknames</b>	
<b>Department of Use:</b>	

<b>SHIPPING INFORMATION</b>		
<b>Hospital Name:</b>		
<b>Attention:</b>		
<b>Address:</b>		
<b>Address 2:</b>		
<b>City, State:</b>		<b>Zip Code:</b>
<b>Phone:</b>	<i>(notified when shipments arrive)</i>	

<b>BILLING INFORMATION</b>		
<b>Hospital Name:</b>		
<b>Address:</b>		
<b>Address 2:</b>		
<b>City, State:</b>		<b>Zip Code:</b>

PURCHASING			
<i>Primary Contact</i>			
<b>Name:</b>		<b>Phone:</b>	
<b>Email:</b>		<b>Fax:</b>	
<i>Alternate Contact</i>			
<b>Name:</b>		<b>Phone:</b>	
<b>Email:</b>		<b>Fax:</b>	

NICU			
<i>Primary Contact</i>			
<b>Name:</b>		<b>Phone:</b>	
<b>Email:</b>		<b>Fax:</b>	
<i>Alternate Contact</i>			
<b>Name:</b>		<b>Phone:</b>	
<b>Email:</b>		<b>Fax:</b>	

ACCOUNTS PAYABLE			
<i>Primary Contact</i>			
<b>Name:</b>		<b>Phone:</b>	
<b>Email:</b>		<b>Fax:</b>	
<i>Alternate Contact</i>			
<b>Name:</b>		<b>Phone:</b>	
<b>Email:</b>		<b>Fax:</b>	