Return completed form to:

EMAIL SShaver@healthcarerealty.com

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HEALTHCARE REALTY

Parking Pass

Tenant name: _____

Building address: _____ Suite #: _____

Phone: _____ Fax: _____ Tenant contact email: _____

Request details

1 **RECIPIENT**

Name: _____ Office Phone: _____ Mobile Phone: _____

2 **TYPE OF PASS (check one):** ☐ General Parking ☐ Temporary ☐ Other _____

3

LICENSE PLATE NUMBER:	MAKE:	MODEL:	COLOR:	YEAR:

Note: No one other than the recipient should use the recipient's parking pass. Vehicles without appropriate parking pass are subject to be towed immediately at vehicle owner's expense.

☐ This request is for an additional or replacement card.

AUTHORIZED BY:

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

Name (print) _____ **Title** _____

OFFICE USE ONLY

Pass number: _____ By: _____ Date: ___ / ___ / _____
Initials

Called requester to pick up on: ___ / ___ / _____ AND/OR Emailed tenant on: ___ / ___ / _____

Date logged: ___ / ___ / _____