

Creche Innovations

Client Information

Primary On-Site Contact Information

Hospital Name: _____

Contact Name: _____

_____ *Last* _____ *First* _____ *M. I.*

_____ *Title* _____ *Department*

_____ *Phone Number* _____ *Fax Number* _____ *Cell Phone*

E-mail Address: _____

Accounts Payable Contact Information

Full Name: _____

_____ *Last* _____ *First* _____ *M. I.*

_____ *Title* _____ *Department*

_____ *Phone Number* _____ *Fax Number* _____ *Cell Phone*

E-mail Address: _____

Shipping Address

Ship To Address: _____

_____ *Address*

_____ *City* _____ *State* _____ *Zip Code*

Phone: _____ Fax: _____

Billing Address

Bill To Address: _____

_____ *Address*

_____ *City* _____ *State* _____ *Zip Code*

Phone: _____ Fax: _____

Additional Information

Tax Information: _____

_____ *Tax Identification Number* _____ *Tax Exempt Certificate*

Comments: _____