Return completed form to:

EMAIL BCrist@healthcarerealty.com

MAIL 1901 S. Union Avenue
Building B, Suite 5001
Tacoma, Washington 98405

HEALTHCARE REALTY

After Hours Unlock Service

Tenant name: ______________________________

Building address: ______________________________ Suite #: __________

Phone: __________ Fax: __________ Requestor's email: __________

Request details

1

DATES

Start date (M/D/YR)		End date (M/D/YR)
______	TO	______
______	TO	______
______	TO	______
______	TO	______
______	TO	______

HOURS

Start time (AM/PM)		End time (AM/PM)
______	TO	______
______	TO	______
______	TO	______
______	TO	______
______	TO	______

2 **LOCATION OF DOOR THAT REQUIRES UNLOCK SERVICE:** ______________________________

3 **PERSON WHO REQUIRES UNLOCK SERVICE:**

Physician Employee(s) Vendor Other: ______________

Name: ______________ Phone: ______________ Email: ______________

4 **REASON FOR UNLOCK SERVICE:**

AUTHORIZED BY:

Signature ______________________________ **Date** __________
(Electronic signature represented by blue type)

Name (print) ______________________________ **Title** ______________

Revised April 2015

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