

BWH - Institutional Account Request

Name of Person Requesting Services: _____

Request Date: _____/_____/_____

Account Address:

Name of Account: _____

Street Address: _____

City: _____

State: _____

Zip Code: _____

Contact:

Contact Name: _____

(Responsible for Issuing Payment within 30 days)

Telephone Number: _____

Contact E-Mail Address: _____

Types of Services to be purchased:

Type of Service Number 1 _____

Type of Service Number 2 _____

Type of Service Number 3 _____

Type of Service Number 4 _____

Type of Service Number 5 _____

Pathology ~ Cytogenetics

Payments:

Cash - Payment in full @ 100% of charges is due 30 days from receipt of invoice.

(Note: Nonpayment of balance will result in inactivation of fund.)

I agree to review monthly account invoice and release payment within 30 days of receipt. I understand that failure to make payment within the agreed upon time will result in inactivation of this account.

Please Print Full Name

Signature

_____/_____/_____
Date

FOR BWH Use Only

F - _____
Institutional Account Assigned
(Special Accounting)

Note: Institutional F# Account will be set up within 14 days upon receipt of signed completed form.