

Return completed form to Healthcare Realty:
FAX 303.980.0296
EMAIL tpelz@healthcarerealty.com
MAIL 11700 West Second Place, Suite 265
 Lakewood, Colorado 80228

Tenant name: _____
 Building address: _____ Suite #: _____
 Phone: _____ Fax: _____ Requestor's email: _____

Request details

1 **RECIPIENT**
 Name: _____ Title: _____
 Phone: _____ Email: _____

2

DOOR LOCATION	RE-KEY	INSTALL LOCK	# OF KEY COPIES
Suite entrance	<input type="checkbox"/>	<input type="checkbox"/>	_____
Restroom	<input type="checkbox"/>	<input type="checkbox"/>	_____
Mailbox	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	_____

We acknowledge and agree a locksmith will be required for lock service and for key copies if a copy-ready key is not available. All charges by the locksmith shall be charged back to the tenant's account.

AUTHORIZED BY:
Signature _____ **Date** _____
(Electronic signature represented by blue type)
Name (print) _____ **Title** _____

..... **OFFICE USE ONLY**

Authorized signature confirmed by: _____ Charges processed on: ____ / ____ / ____ by: _____
Initials Initials

