St. Joseph East Medical Office Building Information Sheet

Name of the Practice:_____ Suite #:_____

Total number of Employees: _____ Total number of Doctors (if applicable):_____

Office Manager Name:_____

Office Manager Phone #:_____

Office Manager Fax #:_____

Office Manager E-Mail:_____

After-hours Emergency Contact Information:

Name: _____ Name:_____

Cell Phone #:_____ Cell Phone #: _____

E-Mail:_____ Email:_____

Please enter your office hours:

M:_____ T:_____ W:_____ Th:_____ F:_____
Sa:_____ Su:_____

Does your office have a security system? (Please circle one) *Yes No* **If yes, enter code here: _____**

How often would you like me to contact you about how things are going in your suite: (Please circle one)

once a week every other week once a month once a quarter only upon request

How do you preferred to be contacted? (Please circle one): *Phone E-Mail In Person*

Please use the following space to let me know of any outstanding requests that have not been resolved, notes about your office, or other important information:

_____
_____
_____
_____
_____
_____

Please return this form to Sarah Newell, Property Manager, NTS Development Company

snewell@ntsdevco.com