



## NEW CLIENT SETUP FORM

|              |       |
|--------------|-------|
| CLIENT NAME: | DATE: |
|--------------|-------|

|                   |                 |
|-------------------|-----------------|
| PHYSICAL ADDRESS: | CITY/STATE/ZIP: |
|-------------------|-----------------|

|                  |                 |
|------------------|-----------------|
| BILLING ADDRESS: | CITY/STATE/ZIP: |
|------------------|-----------------|

|                           |                     |
|---------------------------|---------------------|
| PRIMARY DER CONTACT NAME: | PHONE NUMBER:       |
|                           | AFTER HOURS NUMBER: |
|                           | FAX NUMBER:         |
|                           | EMAIL:              |

|                             |                     |
|-----------------------------|---------------------|
| SECONDARY DER CONTACT NAME: | PHONE NUMBER:       |
|                             | AFTER HOURS NUMBER: |
|                             | FAX NUMBER:         |
|                             | EMAIL:              |

|                       |                     |
|-----------------------|---------------------|
| BILLING CONTACT NAME: | PHONE NUMBER:       |
|                       | AFTER HOURS NUMBER: |
|                       | FAX NUMBER:         |
|                       | EMAIL:              |

If you have any additional contacts you need listed for the account please put their information below:

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## COLLECTION FACILITY INFORMATION:

If you have collection facilities you already utilize please provide the information below or list the city, state and zip code of areas of where you will need a collection facility:

How did you hear about Integrity Testing & Safety Administrators?