## 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 **Pathology ~ Cytogenetics**

Type of Service Number 2 ____________________

Type of Service Number 3 ____________________

Type of Service Number 4 ____________________

Type of Service Number 5 ____________________

**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.**