DIRECTORY AND SUITE SIGNAGE REQUEST FORM

Practice Information: _____

Building Name: Ballas Medical Center_____

Suite Number: _____

Names to be listed under practice. Please list in order you wish them to appear. Please limit main directory and floor directory to doctor's names only.

Main Directory – Last Name, First Name Floor

1. _____
2. _____
3. _____

Floor Directory – Last Name, First Name (Specialty Suite)

1. _____
2. _____
3. _____

Door Directory or Practice Name – Last Name, First Name Floor

1. _____
2. _____
3. _____

Authorized Signature: _____

Name and Title: _____

(Please Print)

Company: _____Date: _____

Please fax to Holladay Properties, Inc.

ATTN: Val Chisholm (913) 693-8001