

FAX REQUEST FOR RM SERVICE

TO: **File & Records Management** DATE _____

FROM: AUTHORIZED NAME _____ TEL # _____

COMPANY NAME _____ CLIENT NUMBER: _____

TYPE OF DELIVERY SERVICE REQUESTED

TYPE: (Circle one) Normal/Next Day - Same Day - Time Sensitive - Emergency - Fax - Mail - Access

DAY REQUIRED: _____ TIME REQUIRED: _____

RETRIEVALS REQUESTED – PLEASE INDICATE IF YOU REQUIRE BOXES OR FILES

<i>BOX #</i>	<i>FILE #</i>	<i>FILE NAME</i>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

PICK UP REQUESTED

CONTAINERS QUANTITY NEW _____ QUANTITY RETURN _____

RETURN FILES _____

MATERIALS ORDERED

BOXES: Quantity _____ Size _____ SHRED BIN _____

BOX BAR CODE LABELS: Quantity _____ FILE CODE LABELS: Quantity _____

SPECIAL INSTRUCTIONS _____

AUTHORIZED SIGNATURE _____ PASSWORD _____