



Client Registration

Company Information

Company Name: _____

Job Site / Location: _____ P.O. Number: _____

Physical Address: Street: _____ City: _____

State: _____ Zip: _____

Job Site / Location: _____ P.O. Number: _____

Physical Address: Street: _____ City: _____

State: _____ Zip: _____

Job Site / Location: _____ P.O. Number: _____

Physical Address: Street: _____ City: _____

State: _____ Zip: _____

Job Site / Location: _____ P.O. Number: _____

Physical Address: Street: _____ City: _____

State: _____ Zip: _____

Main Company Rep: _____ Job Title: _____

E-mail: _____ Mobile Phone: _____

Office Phone: _____ Fax: _____

Site teleSTAT User: _____ Job Title: _____

E-mail: _____ Mobile Phone: _____

Office Phone: _____ Fax: _____

Site teleSTAT User: _____ Job Title: _____

E-mail: _____ Mobile Phone: _____

Office Phone: _____ Fax: _____

Site teleSTAT User: _____ Job Title: _____

E-mail: _____ Mobile Phone: _____

Office Phone: _____ Fax: _____

CONTACT

📞 281-476-9900 ✉ ohs@hasc.com 🌐 hasc.com/telestat

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Billing Information			
Billing Address:	Mail Invoices	Digital Invoices	P.O. Required
Street:	_____		
City:	_____	State:	_____ Zip: _____
BILLING CONTACT			
Contact Name:	_____		Job Title: _____
E-mail:	_____	Phone: _____	Fax: _____
*HASC will not bill insurance.			

Remittance notices should be emailed to ohsaccounting@hasc.com.

Client Special Instructions:

Client Account # _____

HASC Office Use Only:

Client Approval

I authorize Global Health to perform telemedicine services. I have reviewed the above information, terms of service, and respective pricing. This information will be used for all employees directed to Global Health for these services, unless otherwise stated by the employer in writing. Any changes must be made prior to services rendered.

I agree to net 30 days term.

Representative	Title	Signature	Date
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CONTACT

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