



70 Reagan Road Spring Valley NY 10977
Phone: (845) 362-6080

Paramed Order Sheet

Please FAX to (845) 362-0384

Date: _____

Insurance Company: _____

For App #2: 2nd Ins. Co.: _____

Agent Information

Name of Agent: _____

Name of Agency: _____

Address: _____ City: _____ State: _____ Zip: _____

Contact: _____ Phone: _____ Fax: _____

Mailing Instructions: Home Office Agency Other: _____

Applicant Information

Applicant #1 Last Name: _____ First: _____

DOB: _____ SS#: _____ / _____ / _____ Amount: \$ _____

Applicant #2 Last Name: _____ First: _____

DOB: _____ SS#: _____ / _____ / _____ Amount: \$ _____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____

Place of Business: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____

Please Contact Applicant at: Home Work Time: _____ am/pm

If Preset Exam: (min 3 Days) Date: _____ Time: _____ am/pm

Requirements

- | | | |
|---|--|---------------------------------------|
| <input type="checkbox"/> Per Requirements Chart | <input type="checkbox"/> Paramed Exam | <input type="checkbox"/> X-Ray |
| <input type="checkbox"/> MD Exam | <input type="checkbox"/> Blood Chemistry | <input type="checkbox"/> Treadmill |
| <input type="checkbox"/> EKG | <input type="checkbox"/> HOS | <input type="checkbox"/> Other: _____ |

Special Requests

