



Multi-User Subscription Order Form

Send your completed form including check, purchase order or credit card information to:

Mail: American Hospital Directory
166 Thierman Lane
Louisville, KY 40207

Fax: 502-899-7738
(Credit Card and PO orders only)

Type of Account: Single User ID for multiple users (complete this page only)
 Separate Login ID's for each user (complete page two)

Pricing Category: Number of Users 2-5 6-10 11-20 21-35
Per User Price \$355.00 \$315.00 \$285.00 \$275.00

Pricing: _____ X \$ _____ = \$ _____
Number of Users Per User Price (example: 7 Users X \$315.00 = \$2,205.00)

Apps: To add apps to your multi-user account, please contact us at 800-894-8418.
For a list of current apps, please visit <http://www.ahd.com/apps.html>.

Primary Contact: _____

Company Name: _____

Mailing Address: _____

Telephone Number: _____ ext: _____

Email Address: _____

Primary User Name: _____ Password: _____
(leave blank if requesting multiple ID's and no account is needed for the primary contact)

Payment Method

- Please invoice. My purchase order number is: _____ (attach your PO form)
- A check is enclosed in the amount of \$ _____ (payable to American Hospital Directory, Inc.)
- Credit Card: American Express Discover MasterCard Visa

Card Number: _____

Expiration Date: _____ Security Code: _____

Signature: _____

Cardholder Name: _____

Billing Address: _____

(if different)
