ahdcom
AMERICAN HOSPITAL DIRECTORY®

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	$400.00	$355.00	$320.00	$310.00

Pricing: _____ X $ _____ = $ _____
Number of Users Per User Price (example: 7 Users X $355.00 = $2,485.00)

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) _____

For accounts requesting separate User IDs and Passwords Only

Complete the lines below for each additional User ID and Password, as needed.

User ID	Password	User Email Address*

*Supplying an email address is optional. By listing an email address, each user will receive update notifications and have the option to retrieve a forgotten password.