Phone: (661) 888-2777 **Fax**: (661) 888-2778 **Email**: alliedmt@gmail.com
Website: alliedmedicaltransportllc.com

PICK-UP INFORMATION

Mode of Transport: ☐**Round Trip** ☐**One Way** ☐**Gurney** ☐**Wheelchair** ☐**Walk-on**
(*Check all that apply*)

Date: _____/_____/_____ Pick-up Date: _____/_____/_____ Pick-up Time: _____

Requester's Name: _____ Phone: _____

Patient's Name: _____Unit/Room#_____

Pick up Address: _____City: _____ Zip:_____

DROP-OFF INFORMATION

Drop-off Facility: _____Unit/Room#_____

Drop-off Address: _____City: _____ Zip: _____

PAYMENT INFORMATION

☐Private-pay: ☐Check ☐Cash ☐Credit

Responsible Party Name: _____

Contact Number: _____

☐Bill Facility: Facility Name:_____

Authorizing Signature:_____

Authorizing Name:_____ Title:_____