Rental Services Report

Practice Name: ______________________________

Rental Date: ___________________________

Scheduled Start/End Time: ___________ / ___________

Number of Patients Scheduled: ________ How many patients per hour? _______

Name of Primary Contact on-site: _______________________

Actual Start Time: _____________ Actual End Time: _____________

Number of Patients Scanned: __________

Number of Eyes Scanned: __________

Number of Patients Needing Dilation: _________

Please elaborate on any problems or issues encountered during the rental:
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Practice Representative Signature: ________________________

Please leave a copy at the practice and return original to Laura Graham, Business Manager