DeliverHealth SOLUTIONS

eScription One

Graphical Signature Form

ALL INFORMATION MUST BE PROPERLY FILLED IN.
INCOMPLETE FORMS MAY TAKE LONGER TO PROCESS.

CLIENT INFORMATION

Medical Facility (Client): _____

Client Code: _____

Transcription Company: _____

Contact Phone Number: _____
(IN CASE WE NEED MORE INFORMATION)

Clinician Name: _____
(PLEASE PRINT YOUR FULL NAME INCLUDING ANY CREDENTIALS)

Signature (Please keep signature inside dotted box.)

Signature (Please keep signature inside dotted box.)

SUBMIT SIGNATURE BY MAIL

Send this completed form to:

DeliverHealth Solutions, Inc.
ATTN: Signatures
2450 Rimrock Road
Madison, WI 53713

SUBMIT SIGNATURE BY EMAIL

Please scan just the signature block section on this page at **600 DPI** *in* **grayscale**.
Email to esone.support@DeliverHealth.com *Please be sure to include the user's name, client name and client code.*