Information for Preliminary Energy Assessment

Healthcare Facility Information

Company/Entity Name: ____________________________________________________________
Facility Address: __________________________________________________________________
Phone Number: __________________ Fax Number: __________________

DATE: __________________________

THE PROCESS:
Initial information needed

• We need one month of the facility’s electric and natural gas bills.

Approximate Monthly Gas Bill $___________ Approximate Monthly Electric Bill $___________

Type of Facility – Hospital, MOB, Nursing Home, Assisted Living - (Circle One)

How Many Rooms/Beds _____ Census _____ How Many Floors_____

(Yes/No) Food Service _____ Therapy Pool _____ On Premise Laundry ______

Surgery Center _____ How Many Tenants_____ Are Utilities included in CAM Cost______

Additions/Remodels? (Yes/No) ____ If so, when? __________________________

Brief Description: ______________________________________________________________________________________
                                                                                     ______________________________________________________________________________________

Approximate Age of Building ______________ Approximate Sq. Footage __________

• Energy Use Information

  Type of Heating - Boilers _____ Rooftop Units _____ Electric _____ (check one)

  Type of Air Conditioning - PTAC _____ Chiller _____ Heat Pumps ______

  Have you done a lighting upgrade? (Yes/No) ____ If so, how long ago? ______

Comments: ____________________________________________________________________________________________
                                                                                     ____________________________________________________________________________________________

Contact Person Name @ your facility: _________________________________________________
Phone #: __________________ Email: _______________________________________________________

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