RICH ENERGY
solutions company

Information for Preliminary Energy Assessment

Healthcare Facility Information

DATE: _____

Company/Entity Name: _____

Facility Address: _____

_____

Phone Number: _____Fax Number: _____

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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