T&K X-Ray Consultants, Inc.
"Saving you time, frustration, and money."
terry@tleehart.com • 218-940-6152
Fax: 888-879-0259

X-Ray Survey:

Clinic/Facility Name: _____

Complete Mailing Address: _____

_____

Actual Clinic Address (if different from mailing address): _____

_____

Email Address _____

Expected installation date_____

Clinic Phone: _____

Fax: _____

Cell: _____

Please indicate which wall is the NORTH wall.

Anticipated Maximum number of patients per day (x-ray): _____

How many days open per week: _____