Deafnet ASSOCIATION, INC.

P.O. Box 2619 * Hagerstown, MD 21741-2619
301-791-9025 Voice * 301-791-9020 TDD * 301-791-7456 Fax * deafnet@deafnetmd.org

AGREEMENT

This is an agreement between Deafnet Association, Inc. and_____who has requested Deafnet to supply Sign Language Interpreting Services for the dates provided below. Please provide us with the requested information followed by an authorized signature and date. By signing this agreement, you are acknowledging receipt of our current fee schedule dated January 1, 2019, and you are agreeing to our terms and conditions pertaining to our services. You also acknowledge that you represent your agency/organization in billing matters. ***YOU ARE TO EMAIL OR FAX THIS AGREEMENT BACK TO OUR OFFICE PRIOR TO THE REQUESTED DATE(S) SO THAT WE MAY ATTEMPT TO FIND AN AVAILABLE INTERPRETER. AN INTERPRETER MAY NOT BE SCHEDULED IF WE DO NOT HAVE THIS AGREEMENT***. In the event of collection, all costs involved including attorney fees will be paid by your agency/organization. Please retain a copy of this agreement for your records. **FACSIMILE AND EMAIL COPY WILL BE VALID AS AN ORIGINAL.**

Agency/Organization Name:_____

Attention (Billing Contact Person):_____

Billing Address:_____

_____

Email Address:_____

Assignment Date:_____

Assignment Time Start: _____ Expected Finish: _____

Assignment Location: _____

Client(s) Name:_____

Type of Interpreting __ASL __PSE __SEE __Tactile __CUED

Interpreter Needed for: _____(Meeting, Training, Medical Appt., ETC.)

_____ _____
Print Name Date

_____ _____
Title Phone Number

_____ _____
Signature Fax Number /Email