Fax #: (210) 490-1006
Email: requests@deaf-interpreter.com

Request VRI Interpreter

Tell us about your appointment

Appointment Date: (mm/dd/yy)_____ Appointment Time: _____
Deaf Client's Name: _____
Deaf Client's Date of Birth (For Medical Only): _____
Type of Appt/Meeting: _____ Estimated Duration of Appt:_____
Appointment Address: _____
City:_____ State:_____ Zip:_____
Email for VRI Connection:_____

Contact Information Name & Phone:

First Name:_____ Last Name: _____
Title:_____ Organization:_____
Work Phone:_____ Fax Number:_____
Email:_____

Name & Phone of Person Making Request:

☐ Same as contact information above
First Name:_____ Last Name: _____
Work Phone:_____ Email:_____

Payment Information:

Method of Payment: ☐Invoice Mailed ☐Purchase Order ☐Email Invoice ☐Credit Card
Company Name:_____ Purchase Order #: _____
Billing Address: _____
City: _____ State:_____ Zip:_____
Accounting Contact Name:_____ Acct. Contact Phone:_____
Accounting Email (if you want invoice mailed):_____

Credit Card Billing Information: (Please provide the following if you wish to pay via credit card.)

Please note: there is a 3% handling fee applied to all credit card transactions

Card Type: ☐Visa ☐MasterCard ☐American Express
Name as it appears on card:_____
Card Number: _____ Expiration Date (mm/yy):_____
Billing Address: _____
City:_____ State:_____ Zip:_____

Additional Information / Comments: