

SUNCREST
NURSERIES, INC.

DELIVERY INFORMATION

MAILING ADDRESS:

COMPANY NAME: _____

ADDRESS: _____

CITY: _____ ZIP _____

PHONE# _____ FAX# _____

ALT. PHONE, PAGER OR CELL# _____

OWNER: _____ **BUYER:** _____

RECEIVING HOURS: _____ **DAYS CLOSED** _____

DELIVERY ADDRESS:

JOB/YARD NAME: _____

ADDRESS: _____

CITY: _____ ZIP _____

Job/Yard phone# _____ **Alternate phone#** _____

<p>* Can a 35 Foot Tractor-Trailer get to the delivery site safely: Yes or NO please circle one * If the answer is no we must make other arrangements for delivery.</p>
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DIRECTIONS: (*Is there a recommended truck route.*) CROSS

STREET: _____

