BLIND SHIPMENT FORM

PLEASE COMPLETE THE FOLLOWING INFORMATION REGARDING YOUR BLIND SHIPMENT AND RETURN TO US VIA FAX @ 909-428-9289. A FEE WILL BE ADDED TO YOUR FREIGHT BILL FOR THIS SERVICE.

ACTUAL PICKUP LOCATION: (Company name & complete address):

_____

_____

_____

Phone#_____ Contact_____

Pick up date_____ Ready Time_____ Close Time_____

# of Skids_____ Weight_____ Quote Number_____

Hazardous? Yes ☐ No ☐

Item Description: _____ **CLASS:** _____

SHOW SHIPPER AS: (Company name & complete address)

_____

_____

_____

CONSIGNEE / SHIP TO: (Company name & complete address):

_____

_____

_____

BILL TO: (Company name & complete address):

_____

_____

_____

Can we show the Bill to address on the Delivery Receipt?

Special Notes:

_____

HDS Liability on blind shipments is limited to the value of freight charges billed on this shipment.

YOUR NAME: _____ **PHONE NUMBER:**_____

FAX NUMBER: _____