Client Authorisation Form

doctor disk
data professionals

CLIENT DETAILS

Company _____ Date _____

Contact _____ Email _____

Address _____ Phone _____

Suburb _____ Fax _____

State _____ Post Code _____ Mobile _____

JOB DETAILS

MEDIA DETAILS - AS AND IF REQUIRED

Device _____ Brand _____ Model _____

Size _____ Serial No _____ Controller _____

Partition Info _____ Operating System _____ Version _____

OTHER INFORMATION - AS AND IF REQUIRED

Detail of Events ☐ Refer Attached

Software used including any backup software ☐ Refer Attached

Details of files and folders ☐ Refer Attached

AUTHORISATION

1. I/We warrant that I/We hold title to the material being copied or transferred, and I/We hereby indemnify Doctor Disk from any claim for breach of copyright or ownership rights, and from any other claim whatsoever that may arise from Doctor Disk copying or transferring the information and/or data by me/us;

2. I/we acknowledge that Doctor Disk is not liable for the loss of any information or data, for whatever reason, which may occur in the execution or attempted execution of the requested job, I acknowledge and authorise the opening of any relevant media and that doing so may void any warranty in relation to that media, and further, that any physical damage occasioned by any cause whatsoever to electronic or other media, including computer diskettes and tapes, left by me/us at Doctor Disk's premises, will not create any liability upon Doctor Disk other than replacement of said media with new materials of like quality;

3. I/we hereby expressly admit and acknowledge that the fields of computer data recovery, data conversion, duplication and scanning are of great complexity, and accept that Doctor Disk, whilst accepting my/our job in good faith might well encounter subsequent difficulties in its execution not appreciated at the time of acceptance, and I/we hereby absolve Doctor Disk of any claims of liability arising out of any inability to perform the job up to original expectations or representations, or at all, or out of any delays which may arise in its execution, I authorise Doctor Disk to utilise whatever means available including the use of third parties, at their sole discretion, for completion of the requested process;

4. I/we acknowledge that the amount including account charges, if any, will be paid in full C.O.D. unless prior arrangements have been made with our Accounts department. C.O.D. payment terms are by Cash, Bank cheque, or by company/ personal cheque (personal or company cheque must be cleared prior to delivery),

5. I/we acknowledge that any claims for rebates on work which has, according to myself/ourselves, not succeeded according to the standard represented by Doctor Disk will be made in writing within thirty days of the invoice date (or date of cash payment) and will be accompanied by the return of the media supplied by Doctor Disk which is alleged to be at fault, and further that no such claims will be made by myself/ourselves in circumstances where the media in question cannot or will not be so returned.

I declare that I am authorised to act on behalf of the company listed above, have the necessary capacity to authorise the work requested and have read and understand the terms and conditions before me. I hereby authorise Doctor Disk to proceed as detailed above.

Signed _____ Date _____

Name _____ Position _____

INSPECTION REQUIRED
☐ STANDARD
☐ URGENT
☐ PRIORITY

Bank Details
Doctor Disk Pty Ltd
National Aust Bank
BSB: 083 427
A/C: 535 558 529

Address: 14 Trevascus St Sth CAULFIELD 3162
Phone: (03) 9525 3020
Fax: (03) 9502 7669
ACN: 098 113 985
ABN: 18 098 113 985

Office Use Only
Job Number:

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