



Blind Shipments

(Please fill out and scan with Bill of Lading)

Pick up From: _____
(Company Name)

(Street Address)

(City, State, Zip)

Show Shipper as: _____
(Company Name)

(Street Address)

(City, State, Zip) ***must show originating City, State, Zip***

B/L Consignee: _____
(Company Name)

(Street Address)

(City, State, Zip)

Actual Delivery: _____
(Company Name)

(Street Address)

(City, State, Zip)

Bill To: _____
(Company Name)

(Street Address)

(City, State, Zip)

Authorized Name: _____

Authorized Company: _____

Must be party paying blind shipment charges

PRO# _____

Quote#: _____