



ORDER FORM

Date: _____ OrthoPAT users please check here:

Company: _____

Phone Number: _____

Fax Number: _____

P.O. Number: _____

Billing Address: _____

Shipping Address: _____

Contact Name: _____ Email Address: _____

ITEM NUMBER	PRICE	QTY (in cases)	LOT NUMBER	SHIPPING (please circle)
				GR 2 DAY OVERNIGHT
				GR 2 DAY OVERNIGHT
				GR 2 DAY OVERNIGHT
				GR 2 DAY OVERNIGHT
				GR 2 DAY OVERNIGHT
				GR 2 DAY OVERNIGHT
				GR 2 DAY OVERNIGHT
				GR 2 DAY OVERNIGHT
				GR 2 DAY OVERNIGHT
				GR 2 DAY OVERNIGHT
				GR 2 DAY OVERNIGHT

*** SHIPPED FED-EX GROUND UNLESS OTHERWISE SPECIFIED**

Confirmation Number: _____