



225 Parsons St.
Kalamazoo, MI 49007

Order Form

Phone: 877.626.5704
Fax: 269.345.1748

<p>BILL-TO INFORMATION P.O. # _____</p> <p>Date: ___/___/___ Acct. #: _____</p> <p>Customer Name: _____</p> <p>Attention: _____</p> <p>Address: _____</p> <p>_____</p> <p style="text-align: center;">City State Zip</p> <p>Ordered By: _____</p>	<p>SHIP-TO INFORMATION (complete if different from Bill-to Information) (Sorry, we cannot ship to a Post Office Box.)</p> <p>Ship-To Number: _____</p> <p>Customer Name: _____</p> <p>Attention: _____</p> <p>Street address: _____</p> <p>_____</p> <p style="text-align: center;">City State Zip</p> <p>Shipping Method: _____ UPS Ground Unless Otherwise Specified</p>
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Credit Card Information: Visa _____ Master Card _____ Expiration Date: _____
 Card No. _____ Verification No. _____
 Phone: () _____ FAX: () _____

Part Number	Brief Description	Cushion Style (Flat or Sling)	Quantity	Unit Price \$	Total Price \$
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

<p>Options:</p> <p><input type="checkbox"/> Inner Incontinence cover N/C</p> <p><input type="checkbox"/> Sacral Notch N/C</p> <p><input type="checkbox"/> Positioning features (go to page two)</p> <p><input type="checkbox"/> Ultra Ischial/sacral column (pg. Two)</p>	<p>Sub Total \$ _____</p> <p>Rush \$ _____</p> <p>Shipping/Handling \$ _____</p> <p>TOTAL \$ _____</p>
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Positioning Options Models 5000, 7000 and Ultra

- Lateral thigh support anterior to the trochanters N/C
- Pelvic support posterior to the trochanters N/C
- Medial thigh support N/C
- Other (please specify)
- Ultra Ischial/sacral column

Specify Width:

- 4 inches
- 5 inches
- 6 inches
