

ORDER FORM

DEALER INFORMATION:

Date of Request: _____ Account #: _____ Purchase Order #: _____
 Contact Name: _____ Facility/Workplace: _____
 Phone: _____ Fax: _____ E-mail: _____

BILL TO:

First Name _____ Last Name _____
 Street Address _____
 City _____ State _____ Zip Code _____

SHIP TO: (If different than "Bill to" Address)

First Name _____ Last Name _____
 Street Address _____
 City _____ State _____ Zip Code _____
 Phone _____ Fax _____ E-mail _____

PAYMENT METHODS:

- Current Assigned Terms
 Credit Card (Amex/MC/Visa)

- Check or Money Order (*Payable to: Columbia Medical*)

Credit Card # _____ Cardholder's Name (*as it appears on card*) _____
 Cardholder's Signature _____ Expiration Date _____ Security Code _____
 Billing Address _____ City _____ State _____ Zip Code _____

QTY	MODEL #	COLOR	PRODUCT DESCRIPTION/SIZE

CLIENT MARKED FOR NAME: _____

CUSTOMER'S APPROVAL:

Print Name: _____ Authorized Signature: _____ Date: _____

~ ORDER CONFIRMATION WILL BE FAXED WITHIN 24 HOURS ~