4MDMEDICAL

PURCHASE ORDER FORM

CUSTOMER INFORMATION

SOLD TO

Organization: ____________________

Attention: ____________________

Street: ____________________

City: ____________ State: ______ Zip: ______

Phone: ____________ Fax: ____________

Email: ____________________

SHIP TO

Organization: ____________________

Attention: ____________________

Street: ____________________

City: ____________ State: ______ Zip: ______

Phone: ____________ Fax: ____________

PAYMENT INFORMATION

PAYMENT TYPE

☐ Check enclosed for: $____________

☐ Bill us "Net 30 Days" (call 877.463.5818 for details)

☐ Pay by credit card (use the form to the right)

CREDIT CARD INFORMATION

☐ Visa ☐ MasterCard ☐ AMEX ☐ Discover

Card #: ____________ Exp. Date: ______

Name on card: ____________________

Signature: ____________________

ORDER INFORMATION

MODEL	QTY	PRODUCT	COLOR	SIZE	UNIT PRICE	TOTAL PRICE

CONFIRMATION

☐ This confirms a phone order

Name of salesperson: ____________________

☐ I have ordered from 4MD Medical before

☐ Notify me before delivery (may incur additional charges)

Phone: ____________________

AUTHORIZATION

Name: ____________ Title: ______

Signature: ____________ Date: ______

PO#: ____________________

When complete, return with your purchase order by fax 866.611.6999 or email sales@4mdmedical.com