4MD MEDICAL SOLUTIONS 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 #:

4MD MEDICAL SOLUTIONS

TOLL FREE 877-463-5818

FAX 866-611-6999

WEB WWW.4MDMEDICAL.COM

EMAIL SALES@4MDMEDICAL.COM

When Complete, return with your purchase order by fax 866-611-6999 or email sales@4mdmedical.com