

Please send:

___ Lubricant

___ Mailers

___ Work order forms



Rep _____

Labor _____

Lubricant _____

O-ring kit _____

Other _____

Dr(s)	Telephone ()	Date
Practice Name		Contact
Address	City	State ZIP
Payment Method <input type="checkbox"/> Visa <input type="checkbox"/> MasterCard		
_____ - _____ - _____ - _____		Expiration Date _____ / _____ V-Code _____
Signature: _____		

Make	Model	Serial Number	Nature of problem

Note: Insert original into mailing pouch, save copy for your records.

*Please attach a copy of original invoice when requesting warranty.