

BILL TO:

Company/Institution: _____

Attention/Name: _____

Address: _____

City, State, Zip: _____

Phone: (____) _____

Email: _____

SHIP TO:

SAME AS BILLING

Company/Institution: _____

Attention/Name: _____

Address: _____

City, State, Zip: _____

Phone: (____) _____

Email: _____

ITEM	QTY	DESCRIPTION	PRICE	TOTAL
PLEASE NOTE: MINIMUM ORDER OF \$25.00 IS REQUIRED. SHIPPING & HANDLING ADDED AT TIME OF INVOICING.			TOTAL	

Special Requests/Instructions: _____

Contact us at sales@med-associates.com, or call (802) 527-9724 with any questions.

CREDIT CARD:

Visa

MasterCard

American Express

Name as it appears on card: _____

Card #: _____ Exp. Date: _____ Contact #: _____

Security Code # (located on back of card): _____

SHIPPING:

Ground

2 Day

Overnight

>> For Credit Card Orders Only—If using a PO, please fax your institution's form with correct billing & shipping info <<