Order Form

Quality Orthopedic Solutions

BILLING INFORMATION:

P.O.#:________________ Account #:____________________

Company:____

Address:____

City:________________________ Prov./State:____________

Zip.:_________________________ Country:______________

Phone:________________________ Fax:_________________

SHIPPING INSTRUCTIONS: *(If different from billing address)*

Ship to:____

Address:____

City:____

Prov./State:_______________________________________

Zip.:_________________ Country:____________________

Shipping: ☐ Standard Ground ☐ Expedited 2-3 Days ☐ Next Day Special

Catalog #	Description	Qty.

Method of Payment

○ Check Enclosed ○ Bill Me ○ Visa ○ MasterCard

Credit Card #: ____________________ Exp. date: ____________

BERRETTA MEDICAL INC.

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