

Name _____

Type of Practice (CMT, DC, DDS, MD, ND, Pharmacy, Please include professional qualifications)

Company name _____

Address _____

City _____ State _____ Zip _____ Phone _____

FAX _____ E-mail _____

Credit or Debit Only. Visa, MC, AE, - *No Discover Cards*

Primary Card # _____

EXP _____ V code _____ (3 digits on back of card, Amex 4 digit on front)

Name on card _____

Signature _____

Please give a secondary credit card, to be used if the primary card is declined otherwise your
order will be put on hold.

Secondary Card # _____

EXP _____ V code _____

Name on card _____

If your business is subject to California sales tax, please fax us your resale license.

Fax 818.368.0599 Phone 818.360.4871