

Please fax order form to 603-433-6562

Hospital Name \_\_\_\_\_

Bill To Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Ship To Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Contact Name \_\_\_\_\_ Phone \_\_\_\_\_

Email Address \_\_\_\_\_

our Hospital would like the following:

Bag Style # \_\_\_\_\_

Bag Name \_\_\_\_\_

Quantity \_\_\_\_\_

Color of Bag \_\_\_\_\_

Logo Name \_\_\_\_\_

How many colors is your logo? \_\_\_\_\_

Accessory Style # \_\_\_\_\_

Accessory Name \_\_\_\_\_

Quantity \_\_\_\_\_

Fulfillment Program  yes  no

Upon receipt of this form, we will provide you with  
a sales order acknowledgement that will include all charges.  
Thank you for your participation.