DELIVERED ORDER FORM

ORDER #_____

REP PHONE:
PHONE: 877-478-9106
Submit to: orders@checkpointsurgical.com

Purchase Order #: _____
Order Date: _____
Delivery Date Requested: _____

Order Placed By: _____ ☐ **Check for new account**

Email Address: _____

Phone #: (_____) _____ Physician: _____

Hospital: _____

Ship to Address: _____

City: _____ State: _____ Zip Code: _____

Bill to Address (if Same leave blank): _____

City: _____ State: _____ Zip Code: _____

For Credit Card purchases, please call 216.378.9107 for processing.

Add Product Information Sticker or write in information below:

Product #	Description	Lot #	Price	QTY	Total
				Total:	_____

Delivered By: _____
Rep Signature **Print Name** **Date**

Received By: _____
Customer Signature **Print Name** **Date**

For Free Trial Units Only:
I understand that this courtesy unit(s) is to be used on patients according to the intended use of the product. My signature certifies that I am a licensed practitioner eligible to receive this prescription product. This product is being requested for the medical needs of one of our patients and is not intended for, and is prohibited from resale, trade or barter, or credit return. In addition, I agree that we will not, directly or indirectly, charge any individual or third-party or any state or federal entity or program for this courtesy unit.

Hospital Employee/Physician: _____
Hospital Employee/Physician Signature **Print Name** **Date**