



CWI Medical
 Medical Supplies & Health Care Products

FAX ORDER FORM

Please TYPE or PRINT clearly.

Print out the form below and fax to:

CWI Medical
Attn: Customer Service
1-866-588-3337

Date: _____

BILL TO

SHIP TO (fill in only if different from BILL TO)

Name (First/Last): _____

Name (First/Last): _____

Address: _____
(Note: UPS does not ship to P.O. Boxes.)

Address: _____

City: _____

City: _____

State: _____ Zip Code: _____

State: _____ Zip Code: _____

Telephone #: () _____

Telephone #: () _____

Credit Card: <input type="checkbox"/> Discover <input type="checkbox"/> Mastercard <input type="checkbox"/> Visa <input type="checkbox"/> American Express				
Card Holder Name: _____		Expiration Date: _____		
Card Number: _____		Signature: _____		

Product:	Item Code:	Qty:	Price/Unit:	Total:
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

* Please call us at 1-866-588-3888 for Shipping and Tax (NY Residents) Charges. Orders received without this information will not be acknowledged. Business Hours: M-F, 8:30am-5:00pm EST.

Privacy Policy: All your information is kept confidential and will never be shared or sold. For more information on our privacy policy please visit www.cwimedical.com/privacy.html

Subtotal _____
Tax* _____
Shipping* _____
Total _____