



The leader in ocular surface tissue therapies

Please complete and
fax to: (305) 412-4429

For office use only

Customer Code: _____
Rep Code: _____
Assigner: _____

FACILITY INFORMATION:

Facility/Hospital Name: _____
 Purchasing Contact Name: _____
 Phone: _____ Fax: _____ e-mail: _____
 Facility Type: Hospital Surgery Center Private Practice Other: _____

BILLING INFORMATION:

Billing (Accounts Payable) Contact Name: _____
 Billing Address: _____
 City: _____ State: _____ Zip: _____
 Phone: _____ Fax: _____ e-mail: _____
 Federal Tax ID (FEI): _____

SHIPPING INFORMATION:

Shipping Facility Name: _____ Shipping Contact Name: _____
 Phone: _____ Fax: _____ e-mail: _____
 Shipping Address: _____
 City: _____ State: _____ Zip: _____

PAYMENT INFORMATION:

Name of authorized purchaser for this account: _____
 Signature of authorized purchaser: _____
 Payment Method: PO CC (if credit card, complete the following) CC #: _____ Exp. Date: _____
 Name on Credit Card: _____ V Code: _____

REFERENCES: (Company name, contact name, address, phone, fax, and account number):

1. _____

2. _____

3. _____

