Purchase Order Form

Email to: orders@lochnessmedical.com

Date (MM/DD/YY): _____/_____/_____

BILLING	
Company:	
Contact Name/ Title:	
Address:	
City, State, Zip:	
Email:	
Tel:	
Fax:	
Customer PO #:	

SHIPPING	
Company:	
Contact Name/ Title:	
Address:	
City, State, Zip:	
Email:	
Tel:	
Fax:	

QUANTITY	ITEM CODE	DESCRIPTION	UNIT PRICE	TOTAL

SHIPPING METHOD:

- ☐ UPS Ground (3-5 Days)
- ☐ Hand Delivery
- ☐ Other: ____________________

SUBTOTAL:	
Sale Tax (if applicable):	
Shipping:	
Total:	

TERMS AND CONDITIONS

If you are unsatisfied with your product in the first 30 days, please contact your local representative to arrange pickup, replacement, or for any other questions regarding terms and conditions. Products eligible for return within 30 days are subject to a 20% re-stocking fee.

x ______________________________
Print Name

x ______________________________
Signature

To have your order invoiced you must already have established credit with us. Payment can be made by check, ACH, or credit card. Send payments by check to 2775 Broadway, Buffalo NY, 14227. To pay by credit card please call 1-888-506-2658 ext. 3.

Please specify how you would like to receive your invoice:

- ☐ Fax
- ☐ Email

Please email this form to: orders@lochnessmedical.com

Thank you for your business!