

Please mail or fax completed form to:

Laerdal Medical Corporation • 167 Myers Corners Road
 P.O. Box 1840 • Wappingers Falls, NY 12590-8840
 Phone: 877-LAERDAL (523-7325) Fax: 800-227-1143
 customerservice@laerdal.com • www.laerdal.com

For Internal Use Only!

Date _____ CS Initials _____
 Order # _____

1 Have you ordered from us before? No Yes – Bill To # _____

2 Bill To: (Please Print or Type)

Organization: _____ Name: _____ Title: _____ Address: _____ City: _____ County: _____ State: _____ Zip: _____ - _____ Daytime Phone: () _____ Fax: () _____ E-mail Address: _____	<p>What describes your Primary Business or Service? (please check)</p> <p><input type="checkbox"/> Nonprofit/Charitable <input type="checkbox"/> Resale <input type="checkbox"/> Federal/State/Local Govt. <input type="checkbox"/> Individual <input type="checkbox"/> Private Training Company <input type="checkbox"/> Other _____</p> <p>Are you claiming exemption from your State & Local Taxes? <input type="checkbox"/> NO (we are taxable) <input type="checkbox"/> YES (we are exempt)</p> ID# _____ Please send a copy of your State Tax Exempt Certificate <div style="border: 1px solid black; background-color: #cccccc; padding: 5px; text-align: center;"> Your state's applicable exemption certificate or statement must be included with your order for sales tax charges to be waived. </div>
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3 Ship To: (complete only if different from Bill To)

Organization: _____ Name: _____ Title: _____ Address: _____	City: _____ County: _____ State: _____ Zip: _____ - _____ Daytime Phone: () _____ Fax: () _____
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4 Products Ordered

Catalog #	Quantity	Description	Price Each	Total Price
Promotional Pricing: <input type="checkbox"/> No <input type="checkbox"/> Yes CTC# _____				

5 Shipping FOB Origin – Please call for all freight quotes.

6 Method of Payment: (Choose One)

<input type="checkbox"/> Purchase Order: Please attach PO – For Existing Accounts Only <i>Application for Credit Form required for new customers</i> <input type="checkbox"/> Check/Money Order – Amount Enclosed \$ _____ <input type="checkbox"/> MasterCard® <input type="checkbox"/> Visa® <input type="checkbox"/> American Express® <input type="checkbox"/> Discover® Credit Card # _____ Exp. Date _____ Name as it appears on card _____ Signature (required) _____

Subtotal	
Minimum Order*	
Shipping	
Subtotal	
Sales Tax	
Total	

15% restocking fee applies on all returns.
 *Product orders totaling \$100.00 or less, add \$10.00 for minimum order fee (excludes U.S. Military).