Hamilton
Medical
Products
T: 510-799-0100 / F: 510-245-3183
sales@hamiltonmedicalproducts.com

Purchase Order Form

DATE (MM/DD/Y): _____/_____/ 2009

BILL TO		
COMPANY:		
NAME:		
ADDRESS:		
CITY:	ST:	ZIP:
TEL:	FAX:	
EMAIL:		

SHIP TO ☐ Same		
COMPANY:		
NAME:		
ADDRESS:		
CITY:	ST:	ZIP:
TEL:	FAX:	
EMAIL:		

Type of Business:
☐ Accute ☐ Primary Care ☐ Speciality ☐ Long Term ☐ Pharmacy ☐ Home Health ☐ Government ☐ Supplier ☐ Other _____

QUANTITY	ITEM NUMBER	ITEM DESCRIPTION	UNIT PRICE	TOTAL

Shipping Method*
☐ Ground 5-7 Days
☐ Express

Deliver by

Orders over $2000 have free shipping

SUBTOTAL:_____
TAX (CA ONLY):_____
TOTAL:_____

Payment Method: ☐ Visa ☐ Mastercard ☐ Discover ☐ AMEX ☐ Invoice**

Credit Card Number: _____ Exp. Date: _____
CID Code:_____
Name on Card:_____ Signature: _____

Comments/Special Instructions:

*Freight charges will be calculated before processing order. We will notify you and confirm order.
**Invoices are for existing customers with established credit only. Invoices apply to orders greater than $1000. To establish credit please call customer service for credit application.