



Hamilton Medical Products

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

Purchase Order Form

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

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

SUBTOTAL: _____

TAX (CA ONLY): _____

Orders over \$2000 have free shipping

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.