Patient Charting Solutions Since 1955

CUSTOMER REQUEST FOR RETURN / EXCHANGE AUTHORIZATION

Facility Name: ______________________________ Customer #: ____________

Facility Address: ____

City: ________________________ State: ____________ Zip: ___________

INVOICE #____________________ **PO #** ______________________

Reason For Return/Exchange (be specific and note any shipping damage if applicable): __________

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PRODUCT(S) FOR RETURN/EXCHANGE:

CARSTENS ITEM #	QUANTITY	CARSTENS ITEM #	QUANTITY

REPLACEMENT / REORDER (if any):

CARSTENS ITEM #	QUANTITY	CARSTENS ITEM #	QUANTITY

REPLACEMENT / REORDER: Use Same P.O. # Use New P.O. # ____________

Contact Name: ______________________ Dept. / Title: ________________

Phone: ____________ Fax: ____________ Email: ____________________

PLEASE PRINT THE COMPLETED FORM & FAX IT TO:
708-669-1559 ATTN: RETURNS

or

SCAN THE PRINTED FORM AND EMAIL IT TO:

lmarsh@carstens.com.