SPINAL elements

Fax completed Form to 760-607-0155 or Scan and email to CustomerService@SpinalElements.com

Patient Sticker

If no Patient Sticker, provide Hospital Signature

_____

Hospital Signature

Select One:

☐ **Bill only** ☐ **Bill & Replenish**

If replenishment selected, provide shipping information:

Name:

Company:

Shipping Address:

City, State, Zip:

FedEx Shipping Method (Circle one):

Priority 1 (by 10:30 am) **Standard (by EOD)** **Express Saver (2-3 days)**

Saturday Delivery **1st AM (by 8:30 am)**

_____

Hospital Name

_____

Hospital Address

_____

City, State, ZIP

_____

Surgeon Name (First and Last)

_____

Surgery Date

_____

Tray Number

_____

Representative Company

_____

Representative Name (First and Last)

_____

Purchase Order

GENERAL CHARGE SHEET

Part Number	Description	Qty	Lot #	Replenish?	Price Ea	Ext. Price

Total Implant Charges: _____