

BILL/SHIP TO:

Name _____

Address _____

City _____ State _____ Zip _____

Telephone _____ E-mail _____

ORDER:

Selection	Item	Price
<input type="checkbox"/>	25 pack	\$12
<input type="checkbox"/>	50 pack	\$21
<input type="checkbox"/>	100 pack	\$36
	USPS Flat Rate Shipping	\$ 13.65
	Grand Total	\$

PAYMENT:

Card Type American Express Discover MasterCard VISA

Credit Card No. _____

Exp. Date (MM/YY) _____

Name on Card _____

Billing Address if different from above

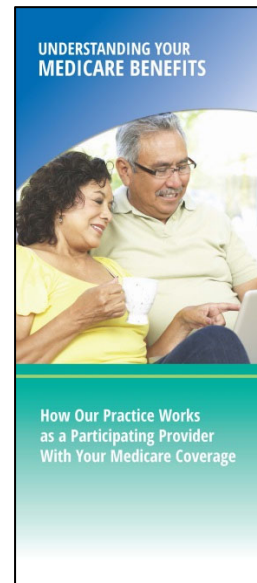
Signature _____

1. Be sure you selected your provider status.
2. Fax completed order to: (800) 974-3479 or
3. E-mail to info@customchirosolutions.com

I would like to receive compliance e-mail updates from Custom ChiroSolutions.

Please select version:

Participating Provider



Non-Participating Provider

