



MedicalScales.net,
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Mail or FAX Order Form

Date:

Billing Information:		Shipping Information			
Name:		Name:			
Company:		Company:			
Address:		Address:			
City:		City:			
State:		State:			
Postal Code:		Postal Code:			
Country:		Country:			
Phone:		Phone:			
FAX:					
Email:					
Payment Information:					
Credit Card Type: <input type="checkbox"/> VISA <input type="checkbox"/> MasterCard <input type="checkbox"/> American Express <input type="checkbox"/> Novus/Discover					
Credit Card Number:					
Credit Card Expiration Date:					
Item #	Color/Option	Description	Qty.	Price Each	Total
				\$	\$
				\$	\$
				\$	\$
				\$	\$
				\$	\$
				\$	\$
				\$	\$
				\$	\$
Subtotal					\$
Shipping Charges (please click here to calculate shipping charges)					\$
Sales Tax (please add 8.625% for New York State deliveries)					\$
Grand Total					\$