PERSONAL TOUCH

Health Care Apparel Inc.

Order Form

Name: _____ Date: _____

Facility Name: _____ Room No.: _____

Address (No P.O. Box): _____

City: _____ State: _____ Zip: _____

Phone: _____

Attn (Person to contact if we have a question): _____

Labeling (Available only to health care facilities): ☐ Yes ☐ No

Amount: _____

Card Account Number: _____

Expiration Date: _____

Signature ***X*** _____

Signature required if you are charging this purchase on your credit card

Please indicate products name, sku #, color, size, and/or other preferences

_____

_____

_____

_____

_____

_____

_____

_____

_____

Total Amount of Goods: _____

Sales Tax: _____

Grand Total: _____

Authorized Signature: _____

P.O. Box 230321, Brooklyn, New York 11223 :: Tel (718) 375-1703 :: Fax (718) 627-0200