To: Universal Medical Inc.

PO Box 1829

Oldsmar, FL 34677-1829

Order Date

Phone 800-423-2767 Fax 800-535-6229 Email: order@universalmedicalinc.com www.universalmedicalinc.com

Account Order Form

*** Please note this form MUST be completed in its entirety. Be sure to indicate item pricing, item numbers & contact information below as requested. If you are submitting a PO issued from your internal system, it is not necessary to complete this form.

Payment Method**

Payment TERMS

If indicated, the following reference number will appear on all related correspondence, shipping papers, and invoices: P.O. NUMBER:

BILL TO ADDRESS: SHIP TO ADDRESS:

Requestor

				UPS			Check			Net 30	
Quantity	Product C	ode	DESCRIPTION						Price per Each		TOTAL
Comments:									SUE	BTOTAL	
						SHIPPI			NG & HANDLING		PREPAID & ADDED
										TOTAL	Subtotal + S&H
Purchasing/Requestor:						Accounts Pa	ts Payable Contact				
Contact Name:											
Contact Phone:						Contact Phone: Contact					
Contact Fax:						Fax:					

Contact Email Address:

SHIP VIA*

Contact Email Address:

^{*} All orders will ship via UPS Ground Service Unless otherwise indicated

^{**} If you are paying by credit card, please use our secure website: www.universalmedicalinc.com