HEALTH EQUIPMENT SERVICES

Please complete this form and enclose in shipment box with unit.

Company Name _____
Shipping Address_____
_____
Phone number _____
E-mail address _____
Contact person _____
FAX _____

*Manufacturer/Model: _____

*Serial #:_____

*Accessories Power cord_____ Power Supply_____ Lead Wires _____
Electrodes_____ Adapters_____ Probes_____
Patient Switch_____ Sound head (serial number)_____
Other _____

***Please provide a thorough description of the problems you are having with this unit.** The more detailed the description of the problem, the less time our technician will have in diagnosing your unit.

What error code is your machine giving? _____
Is the problem Stim? _____Ultrasound _____Both_____
(Note: If you are having a stim problem we will need the lead wires/electrodes)
Which channel are you having problems with? _____

Who can we talk to about the problem? _____
Is the problem intermittent? _____
Description of problem_____
_____
_____
_____

IF USING
UPS/FEDEX Health Equipment Services
SHIP TO: 25 S. Sixth Street, Ste. 203
Indiana, PA 15701

US MAIL: 574 Philadelphia St., Ste 203
Indiana, PA 15701

We accept Visa/MC or can ship back COD