



### Service Requisition Form

Fill out the information below. Enter N/A for fields that do not apply. Send this form in with your unit to be serviced. Do **NOT** return charger or accessories unless defective or requested by our technician. We will contact you with our findings once the unit has been evaluated. Thank you.

Product Description: \_\_\_\_\_ Serial Number: \_\_\_\_\_  
 Reason for Return: \_\_\_\_\_ Purchase Order (If available): \_\_\_\_\_  
 Reason for Return (If OTHER be as detailed as possible): \_\_\_\_\_

**REQUESTOR NAME:**

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_  
 Email Address: \_\_\_\_\_ Telephone Number: \_\_\_\_\_  
 Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 By signing above, "I certify this item has been cleaned prior to return."

**BILL TO INFORMATION:**

Facility Name: \_\_\_\_\_  
 First Name \_\_\_\_\_ Last Name: \_\_\_\_\_  
 Address 1: \_\_\_\_\_ Address 2: \_\_\_\_\_  
 P.O. Box: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

**SHIP TO INFORMATION (IF DIFFERENT FROM ABOVE):**

Facility Name: \_\_\_\_\_  
 First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_  
 Address 1: \_\_\_\_\_ Address 2: \_\_\_\_\_  
 P.O. Box: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

**BMD CONTACT INFORMATION:**

Shipping Address:  
 61 Soundview Road  
 Guilford, CT 06437  
Telephone:  
 (800) 224-6633 ext. 226  
Email Address:  
 techsuprt@biomeddevices.com