

PRODUCT ORDER FORM

Please fill out completely. Orders cannot be processed without all necessary information.

FAX TO: (630) 690-8448

***PO Number** _____



WHEATON BRACE CO.

*innovators of pediatric
orthopedic products*

Wheaton Brace Co.
391 S. Schmale Rd.
Carol Stream, IL 60188-2756
www.wheatonbrace.com

Toll-Free **(800) 227-6769**
Local **(630) 690-5795**
Fax **(630) 690-8448**
sales@wheatonbrace.com

SHIP TO:

Name _____
Company _____
Address _____
City _____ State _____
Zip _____ Country _____
Phone (____) _____
Fax (____) _____

BILL TO: Check here if shipping/billing address are the same

Name _____
Company _____
Address _____
City _____ State _____
Zip _____ Country _____

Quantity	Item No.	Please check one if applies:			Description
		L Only	R Only	Pair	
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

REQUESTED SHIPPING:

- Overnight
- 2nd Day
- 3 Day
- Ground

COMMENTS:

CONFIRMATION:

- Faxed acknowledgement requested
- Phone confirmation requested

Approved by: _____ Date: _____