



Independent Medical Associates

Order Form

Please fill out the form below and fax or email it to: 888-548-1462 / CRogers@I-MA.com. (*Required Field)

*Account #: _____

*Contact Name: _____

*Account Name: _____

*Contact Phone: _____

*Ship To Address: _____

*Contact Fax: _____

Contact E-Mail: _____

*PO Number: _____

*Bill To Address: _____

Delivery Method (*All orders are shipped same-day if recieved before 4pm Monday-Friday unless otherwise noted. Typical ETA is 2-3 days from delivery date. Freight charges apply.*)

UPSRED UPSBLU FEDEX

UPS GROUND OTHER

Payment Options (*Our terms are NET30*):

Invoice

Credit Card

 Visa Mastercard

Other/Account Number/Comments:

Credit Card Number: _____

Expiration Date: _____

Three Numbers on Back: _____

*Part Number	Part Description	*Qty	*Unit	Unit Price	Total

Comments:

Office Use Only

Confirmation #: _____ Delivery Date: _____ Backorders: _____

Comments: