Express Order Form

Mohawk Medical Mall
Phone: 800-962-5660 335 Columbia Street
Fax: 315-797-0365 Utica, NY 13503

Customer Information

Company Name:
Contact Name:
Adress1:
Adress2:
City / State / Zip:
Phone / Fax:

Please Ship This Order:

- ❑ Weekly
- ❑ Bi-Weekly
- ❑ Monthly

Quantity	Item #	Description	Price	Ext Price
			Total	

Payment Information

Credit Card Type: ❑ AMEX ❑ Visa ❑ Mastercard ❑ Discover

Card Number: _____

Exp Date: _____ Name on Card: _____

I approve Mohawk Medical Mall to bill my credit card upon each shipment of this standing order and agree to notify Mohawk Medical Mall within 30 days of cancelling this order

_____ _____
Signature Date

_____
Printed