Blue Phantom™
A division of Advanced Medical Technologies, LLC

Fax Credit Card Product Order Form

Purchaser Information

Customer Name: ____

Institution Name: ______________________________ Department: _____________________________

Shipping Address: ____

City: ______________________ State/Province ___________________ Zip: ______________

Telephone: ______________________________ Email: _____________________________________

Product Information

Qty	Product	Unit Price*	Total

* Price does not include shipping and handling fee nor Washington State sales tax if applicable

Payment Information

Credit Card (circle one)

VISA MasterCard American Express

Cardholder's Name: ____

Credit Card Number: ____________________________________ Expiration Date: __________/__________

Security Code Number (CVV2): _________

Billing Address of Cardholder:

City: ________________________ State/Province: ______________ Zip: ____________

Telephone: ________________________ Email: _____________________________________

Please mail or fax your order to:
Blue Phantom™ 6200 111th Ave NE | Kirkland, WA 98033 | Telephone (425) 828-7886 | Fax (425) 822-6631

Authorization Type

Amount USD $ ________________________ Order/Invoice # __________________________ Regional Sales Manager Name____________________________

I authorize Blue Phantom™ a division of Advanced Medical Technologies, LLC, to charge my credit card in the amount stated above. If I feel that any charge was made in error, I will notify the Accounts Payable personnel on order to resolve the issue per the terms of the quotation and/or invoice, but acknowledge and agree that all charges are irrevocable and undisputable.

____ __________________________

Authorized signature of cardholder Date

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