



**MEDICAL DEVICE TRACEABILITY**

COMPLETE FIRM NAME: \_\_\_\_\_ D.B.A.: \_\_\_\_\_

BILLING ADDRESS: \_\_\_\_\_  
STREET CITY STATE ZIP

SHIPPING ADDRESS: \_\_\_\_\_  
STREET CITY STATE ZIP

TELEPHONE: \_\_\_\_\_ FAX #: \_\_\_\_\_

NATURE OF BUSINESS:  HOSPITAL  SLEEP LAB  DME  OTHER

E.I.N. # \_\_\_\_\_ STATE RESALE OR EXEMPTION #: \_\_\_\_\_ (PLEASE ATTACH COPY)

**CUSTOMER AGREES THAT THE ABOVE STATEMENT IS TRUE TO THE BEST OF CUSTOMER'S KNOWLEDGE. CUSTOMER AGREES TO BE RESPONSIBLE FOR PROVIDING A CLEAR PATH OF MEDICAL DEVICE TRACEABILITY.**

CUSTOMER'S SIGNATURE: \_\_\_\_\_ TITLE: \_\_\_\_\_

PRINTED NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

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**PLEASE DO NOT WRITE BELOW THIS LINE - OFFICE USE ONLY**

SALES: \_\_\_\_\_ DATE: \_\_\_\_\_