



30 DAY GUARANTEE REPLACEMENT REQUEST

SLEEPNET ACCOUNT NUMBER: _____

COMPLETE BUSINESS NAME: _____

BUSINESS STREET ADDRESS: _____

BUSINESS CITY, STATE, ZIP: _____

CONTACT NAME: _____ **PHONE NUMBER:** _____

REF/ITEM # TO REPLACE: _____ **ITEM DESCRIPTION:** _____

LOT NUMBER: _____ **HOW LONG WAS MASK USED?** _____

REASON FOR REPLACEMENT: _____

AUTHORIZED SIGNATURE: _____ **TITLE:** _____

PRINTED NAME: _____ **DATE:** _____

Sleepnet Contact Phone Number: **800-742-3646**

Sleepnet Contact Fax Number: **603-758-6699**

Sleepnet Corporation reserves the right to change, discontinue, or limit quantities with regard to its 30 day Satisfaction Promise at any time.

PLEASE DO NOT WRITE BELOW THIS LINE - SLEEPNET AUTHORIZED USE ONLY

SLEEPNET MARKETING DEPARTMENT:

REPLACEMENT APPROVED BY: _____ DATE: _____ CUSTOMER ID: _____

REPLACEMENT SALES ORDER #: _____ SHIP DATE: _____

ITEM(S) SHIPPED: _____ COMPLAINT/FEEDBACK #: _____

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