



# Order Form

**Independent Medical Associates**

**Please fill out the form below and fax or email it to: 888-548-1462 / ORDERS@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

Credit Card Number: \_\_\_\_\_

Expiration Date: \_\_\_\_\_

Three Numbers on Back: \_\_\_\_\_

Other/Account Number/Comments:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

Comments:

**Office Use Only**

Confirmation #: \_\_\_\_\_ Delivery Date: \_\_\_\_\_ Backorders: \_\_\_\_\_

Comments: