



Please complete this form and enclose in shipment box with unit.

Company Name _____
Shipping Address _____

Phone number _____
E-mail address _____
Contact person _____
FAX _____

*Manufacturer/Model: _____

*Serial #: _____

*Accessories Power cord _____ Power Supply _____ Lead Wires _____
Electrodes _____ Adapters _____ Probes _____
Patient Switch _____ Soundhead (serial number) _____
Other _____

***Please provide a thorough description of the problems you are having with this unit.** The more detailed the description of the problem, the less time our technician will have in diagnosing your unit.

What error code is your machine giving? _____
Is the problem Stim? _____ Ultrasound _____ Both _____
(Note: If you are having a stim problem we will need the lead wires/electrodes)
Which channel are you having problems with? _____
Who can we talk to about the problem? _____
Is the problem intermittent? _____
Description of problem _____

IF USING
UPS/FEDEX Health Equipment Services
SHIP TO: 25 S. Sixth Street, Ste. 203
Indiana, PA 15701

US MAIL: 574 Philadelphia St., Ste 203
Indiana, PA 15701

We accept Visa/MC or can ship back COD

TEL 800.253.5555 • 724.349.4400 • FAX 724.349.1017