Credit Card Authorization Form

Trial Unit Agreement- Electro Flo 5000 Airway Clearance System

PLEASE PRINT OUT AND COMPLETE THIS AUTHORIZATION FORM AND RETURN TO US VIA FAX 858-483-9827

Card Holders Name_____

Phone Number_____

Billing
Address_____
_____
_____

Card Type Type- Visa_____Master Card_____ Discover _____ Amex_____

Credit Card Number_____

Expiration Date _____

CVC Code _____

Amount to Charge $___2950.00_____

I agree to return the Electro Flo 5000 at the conclusion of the 30-day trial, unless an extension of the trial period is approved. If not returned when agreed upon, I authorize Med Systems Inc. to charge the agreed amount listed above.

Card Holder

Signed :_____

Dated:_____

Printed Name_____

Once Signed return the completed form to:

Med Systems Inc.

Fax: (858)-483-9827

Thank You!

Med Systems Inc
2631 Ariane Drive
San Diego, CA. 92117
www.medsystem.com
(800)345-9061