Medical Device Authorization Form

Please fax this form to (305) 515-6038 or email to info@airodmedical.com.
Once we receive this form we will continue processing your order.

Name of Facility:_____

Attention:_____

Address: _____

City and State: _____ Zip: _____

Phone:_____ Fax:_____

Email:_____

I hereby authorize the representative(s) below to order medical devices for this facility.

_____

_____

Physician/Authorized Prescriber Signature: _____

Physician/Authorized Prescriber Name: _____

State License Number/DEA Number: _____

I hereby acknowledge that I am aware that medical devices are intended for use by a physician or person certified or trained to use such a device.

Name: _____

Title: _____ State License/Certification Number: _____

Signature:_____ Date:_____

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