JMS
MED SUPPLY

Please Send to: Invoice@JMSMedSupply.com

Customer Information Form

BILL TO

Clinic Name:_____

Clinic Address:_____

City:_____ State:_____ Zip:_____

Email:_____

Phone:_____

SHIP TO

☐ Same As Above

Clinic Name:_____

Clinic Address:_____

City:_____ State:_____ Zip:_____

Email:_____

Phone:_____

CREDIT CARD

Name on Card:_____

Card Number:_____

Security Code:_____ Exp:_____

Print Name:_____

Sign Name:_____ Date:_____

PAYMENT TERMS

Upon receipt of products to purchaser, JMS Med Supply will invoice purchaser the purchase price of products and purchaser will pay account in full in accordance with the specified terms and conditions on each invoice. By signing below, purchaser agrees they have read the above terms and conditions and agrees to abide by them and certifies that the information given above is complete and accurate.