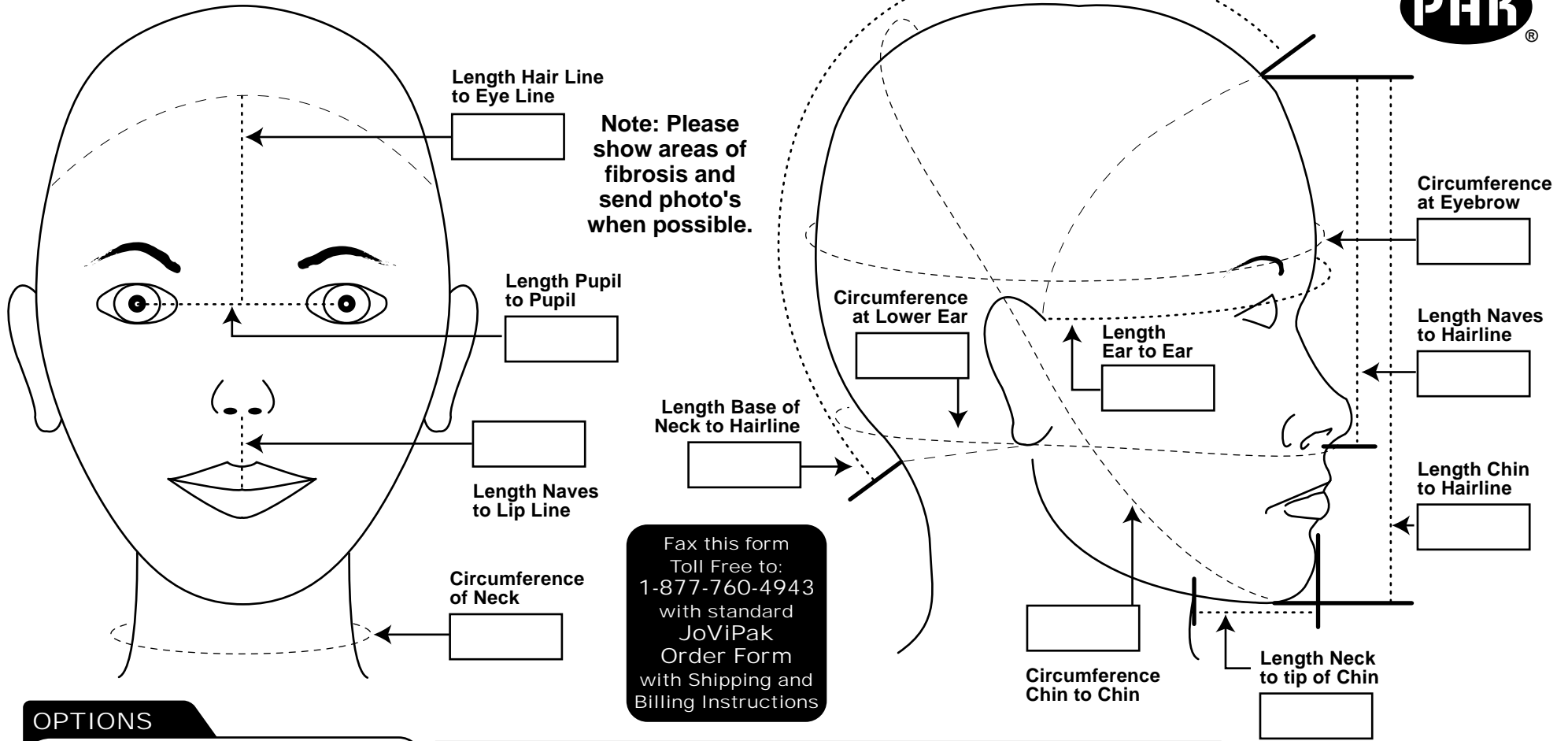


# Custom (Made-to-Measure) JoViPak® Head Form



Fax this form  
Toll Free to:  
1-877-760-4943  
with standard  
JoViPak  
Order Form  
with Shipping and  
Billing Instructions

## OPTIONS

- Full Face Mask
- Open Face Mask  
with eyes and nose exposed
- Chin Strap  
with eyes, nose and mouth exposed
- Separate Eye Piece
- Trach Collar

Special Needs or Considerations i.e. radiation burn or scarring

Patient Name \_\_\_\_\_ or Reference# \_\_\_\_\_ Date \_\_\_\_\_



**JoViPak®**  
 19625 62nd Ave S. Suite B101  
 Kent, WA 98032  
 Phone: (206) 575-1656  
 Toll Free: 1 (866) 888-5684  
 Email: info@jovipak.com  
 www.jovipak.com

# Order Form

Fax this form  
 Toll Free to:  
**1-877-760-4943**

Date \_\_\_\_\_  
 Customer ID# \_\_\_\_\_  
 PO# \_\_\_\_\_

## BILL TO

Business \_\_\_\_\_  
 Attention \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_  
 Zip \_\_\_\_\_ Phone \_\_\_\_\_

## SHIP TO

Business \_\_\_\_\_  
 Attention \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_  
 Zip \_\_\_\_\_ Phone \_\_\_\_\_

## SHIPPING: PLEASE SPECIFY

Business Address  Residential Address (\$5 extra)  
 Ground  Next Day Air  
 2nd Day Air  3 Day Select

## PAYMENT INFO

Check (Payable to Tri-D Corporation)  Bill to Account

Credit Card  Visa  MasterCard  
 Exp. \_\_\_\_/\_\_\_\_/\_\_\_\_  American Express  
 Card# \_\_\_\_\_

Cardholder \_\_\_\_\_  
 (print name)  
 Signature \_\_\_\_\_

## CONTACT INFORMATION

Patient \_\_\_\_\_  
 Phone \_\_\_\_\_  
 Measured By \_\_\_\_\_  
 Phone \_\_\_\_\_  
 Email \_\_\_\_\_  
 Order Confirmation will be FAXED to: \_\_\_\_\_

This Form Must  
 Accompany Every Order

\*Right or Left

\*Primary or Secondary

QTY	PRODUCT #	*R or L	SIZE	*P or S	UNIT PRICE
<b>PRODUCT SUBTOTAL</b>					