Clear Form

Recovery Sciences P.O. Service Invoice

One Patient Per Sheet per PHI guidelines

Independent Contractor : _____ **Account / Facility Name:** _____

Territory Manager Name : _____ **Purchase Order Number:** _____

Date Placed	Patient Name	Patient Signature *Must be completed at time of placement*	Device Information	Placed At (check box)	Service Fee
			☐ OL1000 ☐ SpinaLogic ☐ Cybertech Serial Number(s): _____	☐ Facility ☐ Doctor's Office ☐ Patient's Home	
				TOTAL FEE :	

If available, place serial number sticker from device below

INDEPENDENT CONTRACTOR SIGNATURE: _____ **DATE:** _____

PAYMENT APPROVED BY: _____ **DATE:** _____

Terri Melo, Sales Operations Specialist

Fax completed form to **760.597.8476**