



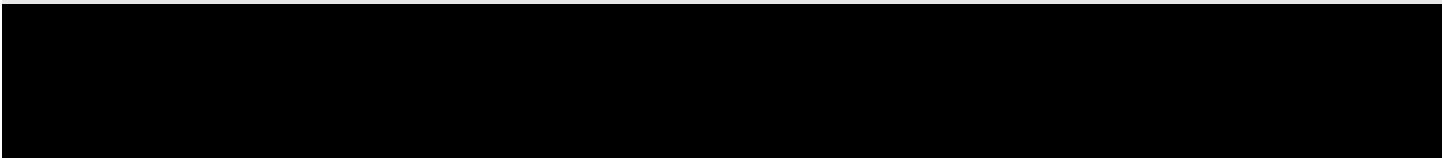
# Repair Form

PO#:	ORDER#:
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Try Touch Services, Inc.

1. Customer/Hospital Contact Information

Contact Name:			
Hospital:		Date:	
Shipping Address:	Street:	City:	State: Zip:
Name of Billing:	Street:	City:	State: Zip:
Billing Address:	Street:	City:	State: Zip:
Email:		Phone:	Ext:



Please list products you would like to service

Type	Manufacturer/Model	Qty	Serial Number	Issue
Monitor Software revision:				
Module Software revision:				
Telemetry Frequency:				
Fetal Transducer				
Patient Cable				
Infusion Pump				
Suction Regulator				
Other				

Please include SN#:

Notes:	Return Shipping Method	FedEx Acct.
	<input type="checkbox"/> Standard Ground <input type="checkbox"/> 2 Day <input type="checkbox"/> 3 Day <input type="checkbox"/> Overnight	UPS Acct.

Signature of release: I hereby verify that the above information is correct and I am sending these items to Avante Patient Monitoring to be repaired.  
I also verify that the products have been decontaminated.

Sign name: \_\_\_\_\_ Date: \_\_\_\_\_