

**EVALUATION REQUEST FORM**



**INNOMED, INC.**

103 Estus Drive  
Savannah, GA 31404

DATE \_\_\_\_\_

CUSTOMER ACCT  
CODE/NO \_\_\_\_\_

FACILITY NAME \_\_\_\_\_

BILLING ADDRESS \_\_\_\_\_

BUYER NAME \_\_\_\_\_

TELEPHONE \_\_\_\_\_

FAX \_\_\_\_\_

EMAIL \_\_\_\_\_

ATTENTION LINE \_\_\_\_\_

SHIPPING ADDRESS \_\_\_\_\_

SHIPPING CARRIER **FEDEX** **UPS**

SHIPPING METHOD \_\_\_\_\_

SHIPPING ACCT # \_\_\_\_\_

SURGERY/CASE DATE \_\_\_\_\_

**ITEMS REQUESTED**

QTY	PART #	DESCRIPTION
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please return form via fax to (912)236-7766 or email to [chасыtу@innomed.net](mailto:chасыtу@innomed.net).