Orders@UniteMedical.net
P/F: 833.TO-Unite (833.868.6483)

ORDER FORM

BILL TO:

Company Name: _____ DBA: _____

Address: _____ City: _____ State: _____ Zip: _____

Owner(s) / Principal(s): _____ Purchasing Contact: _____

Email: _____ Phone: _____ Fax: _____

SHIP TO:

Business Type: Corporation ☐ Partnership ☐ Sole Proprietorship ☐ LLC ☐

Company Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Accounts Payable Contact: _____ A/P Phone: _____

Company Website: _____ Email: _____

Tax Information:

Tax ID: _____

☐ Product Purchased for resale only (Please provide copy of resale certificate)
☐ Nonprofit or charitable Organization exempt from sales and/or use tax (Please provide copy of resale certificate)
☐ Product to be purchased is tax exempt in: State, County (Please provide copy of resale certificate)

ORDER INFORMATION:

CareStartTM COVID-19 Rapid Antigen minimum order QTY of 1 case (640 test = $8,960.00).

Shipping Option: ☐ Next Day ☐ 2 Days ☐ Ground

Order Quantity: ☐ 1 Case ☐ 2 Cases ☐ 3 Cases ☐ 4 Cases ☐ 5 Cases ☐ 6 Cases ☐ 7 Cases ☐ 8 Cases ☐ _____

CREDIT CARD DETAILS (3% Processing Fee):

Processing fees do not apply to bank or wire transfers.

Card Holder Name: _____

Card Number: _____ Zip Code: _____

Expiration: _____ Security Code: _____

Print Name: _____ Sign Name: _____ Date: _____

WHAT TO EXPECT AFTER ORDERING:

1. Invoice will follow once order is received
2. Payment required in full prior to shipping (Credit Card, Bank Transfer, Wire)
3. Shipping confirmation with tracking provided

20 Tests per Box

32 Boxes per Case (Minimum Order QTY)

20 Cases per Pallet

Rep ID: _____