

5. Your Mix & Match Stickers:

Sticker #	Qty	Sticker #	Qty	Sticker #	Qty	Sticker #	Qty	Sticker #	Qty
1		13		25		37		49	
2		14		26		38		50	
3		15		27		39		51	
4		16		28		40		52	
5		17		29		41			
6		18		30		42			
7		19		31		43			
8		20		32		44			
9		21		33		45			
10		22		34		46			
11		23		35		47			
12		24		36		48			

6. Sticker Price:
 1-19 rolls/packs \$7.99 each
 20-49 " \$6.99 each
 50-149 " \$5.99 each
 150 & up " \$4.99 each

Total quantity _____
 Price per unit **x** _____
 Sticker Subtotal \$ _____

7. Your Other Products:

Item #	Qty	Description	Unit Price	Total
1				
2				
3				
4				
5				
6				
7				
8				
9				

Comments or Suggestions:

Shipping & Handling

Subtotal	Add to order
up to \$99.99	\$13.95
\$100.00 - \$149.99	\$15.95
\$150.00 - \$249.99	\$21.95
\$250.00 - \$399.99	\$26.95
\$400.00 and up	10% of order

UPS Ground in contiguous USA.
 Additional charges apply in some areas and on special orders. Shipping and Handling are non-refundable.

Personalized Product Subtotal (from opposite page)

Personalized Product Subtotal (from opposite page)	\$ _____
Sticker Subtotal (from above)	\$ _____
Order Subtotal	\$ _____
GU, VI & PR add 15%	\$ _____
Shipping & Handling (see chart)	\$ _____
AK & HI add \$20.00	\$ _____
Canada add \$23.00	\$ _____
*Orders to these states add sales tax.	\$ _____
Catalog prices do not include sales tax.	\$ _____
TOTAL	\$ _____

Thank you for your order!

Same Day Shipping!
 Order by 3 p.m. EST

MediBadge, Inc. currently collects applicable sales tax for the following states:
 *AR, CA, GA, IA, IL, IN, KY, LA, MD, MI, MN, NC, NE, NJ, NY, OK, PA, SD, UT, VA, WA, WI, WV

1. Billing Info:

Company _____ Contact Name _____

Street Address _____ P.O. Box _____

City _____ State _____ Zip _____

Phone () _____ Fax () _____

Check/Money Order Enclosed Bill Me (net 10 days)

Purchase Order # _____

Purchase Orders required for all orders shipped to Hospital address. Attach or fax original PO with this order form. Please do not send "Confirming" or "Duplicate" orders.

Visa MasterCard American Express Discover

Credit Card Number _____

Signature _____

Name on Card _____ Exp. Date _____

2. Ship To:

Name _____

Street Address _____ P.O. Box _____

City _____ State _____ Zip _____

Street address and suite number required for UPS delivery.

3. Promo Code:

Please enter code from yellow box on the back of this catalog

Person to Contact

Phone () _____ Fax () _____

E-mail _____

Subscribe me to your E-mail Newsletter!

4. Office Specialty (Please check the appropriate box):

<input type="checkbox"/> Pediatrician	<input type="checkbox"/> Hosp. - Peds	<input type="checkbox"/> General Dentist	<input type="checkbox"/> Bank
<input type="checkbox"/> Family Practice	<input type="checkbox"/> Hosp. - ER	<input type="checkbox"/> Pediatrician	<input type="checkbox"/> Credit Union
<input type="checkbox"/> ENT	<input type="checkbox"/> Hosp. - Lab	<input type="checkbox"/> Orthodontist	<input type="checkbox"/> School
<input type="checkbox"/> Allergy/Asthma	<input type="checkbox"/> Hosp. - Radiology	<input type="checkbox"/> Health Dept/WIC	<input type="checkbox"/> Daycare
<input type="checkbox"/> Orthopedist	<input type="checkbox"/> Lab - non-hospital	<input type="checkbox"/> Nurse	<input type="checkbox"/> Dance/Gymnastics
<input type="checkbox"/> Urgent Care	<input type="checkbox"/> Radiology - non-hospital	<input type="checkbox"/> Nurse Practitioner	<input type="checkbox"/> Ophthalmology
<input type="checkbox"/> Surgery	<input type="checkbox"/> Volunteer Svcs.	<input type="checkbox"/> OB/Maternity	<input type="checkbox"/> Other _____