

**Hospital Product Shipment Approval Form**

PO ATTACHED: Y N PO #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ N/A, PAY BY \_\_\_\_\_\_\_

Date Requested: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of last order: \_\_\_\_\_\_\_\_\_\_\_\_

Date of first Surgeon CALL to this account: \_\_\_\_\_\_\_\_\_

Total # of product shipped to this account: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Salesperson Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SPID: \_\_\_\_\_\_

Sale Group Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sales Group Director’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hospital Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Account #: \_\_\_\_\_\_\_\_\_\_

City, State:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name of Parent Hospital: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# of Beds: \_\_\_\_\_\_\_\_\_\_\_\_\_. 1° Contact Name: \_\_\_\_\_\_\_\_\_\_

Total # of surgeons at this facility: \_\_\_\_\_\_\_

# of product requested: **BP105M**\_\_\_\_\_\_\_. **BP105C** \_\_\_\_\_\_ **BP105CY** \_\_\_\_

Negotiated Price: \_\_\_\_\_\_\_\_ [ ] standard pricing. [ ] Special

Completed by BSSM: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_

Notes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

IS THIS ACCOUNT CURRENT: Y N Date of last payment: \_\_\_\_ Net: \_\_\_d

Sign off by: Louis Cornacchia, CEO.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

Comments: