PEAKS & PLAINS MEDICAL, INC.
Fax to: 1-800-886-1747
Phone : 1-800-585-4201

Facility Purchase

FACILITY _____TYPE_____

ADDRESS_____
Street City State Zipcode

FACILITY
CONTACT NAME_____Tel_____Fax_____

Client Contact E-mail address: _____

I agree to be responsible for any charges for supplies ordered for this facility. I understand that all bills must be paid 30 days from the date of the invoice. I have received a copy of the Return Policy and the Protocol for Resolving Complaints.

In the event that legal action must occur for collection purposes, the venue for such or any action shall be resolved in Spokane County, State of Washington. Should a dispute arise, the action shall be resolved by mandatory arbitration. In the event of any breach of this Contract, the party responsible for the breach agrees to pay reasonable attorney's fees and costs, including costs of service of notices, incurred by the other party. In the event that an invoice is not paid within 30 days from the date of the invoice, interest shall be charged at a rate of 1 ½ % per month (18% per annum).

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X_____ X_____ _____
Signature of Person Authorized to Order Supplies **DATE** **Sales Person**

Bill to, if different address from above_____ Tel_____

Address_____

ITEM	DESCRIPTION/SIZE	QUANTITY