

# ACP MEDICAL SUPPLIES INC.

118 BAYWOOD AVENUE

LONGWOOD, FL 32750

Tel: (407) 830-0588 Fax: (407) 830-1588 Toll Free Tel: 1-877-248-4539

*www.acpmedical.com*

## ACP RETURN MERCHANDISE AUTHORIZATION FORM

### Customer Information:

Name: \_\_\_\_\_

Company: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

### Product Information:

<u>Invoice Date</u>	<u>Invoice #</u>	<u>Product Code</u>	<u>Lot/SN #</u>	<u>Qty</u>	<u>Remarks</u>

### Reason(s) for Return:

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### Return/exchange Handling

<input type="checkbox"/> Store Credit	<input type="checkbox"/> Refund to Credit Card
<input type="checkbox"/> Exchange	Credit Card # _____ Exp. ___ / ___

**PRINT NAME** \_\_\_\_\_ **SIGNATURE** \_\_\_\_\_

INTERNAL USE ONLY:	
RMA#	RETURN TO <input type="checkbox"/> Repair <input type="checkbox"/> Quarantine
DATE RECEIVED	<input type="checkbox"/> Warehouse
CHECKED BY	APPROVED BY

- A Return Representative must contact you with an RMA number before you send your item back.
- Please fax the completed form to (407) 830-1588
- Enclose RMA form along with the returned product packed in the original packaging. Packages sent without a RMA# will not be processed.
- If returned item are not received within 10 days from the day the RMA number was issued, the RMA number will be voided and the item(s) will not be accepted for return.