

(Tel: 800-356-3362 or 613-860-0333)

ORDER FORM

SHIP TO	BILL TO
Name:	Name:
Address:	Address:
(No P.O. boxes)	
City:	City:
State/Province:	State/Province:
Country:	Country:
Zip/Postal code:	Zip/Postal code:
EIN/Social Security #:	Tel.#:
Tel.#:	

OPTOMETRIST/OPTICIAN SECTION				CLIENT SECTION	
Prescription - near vision	R	L	Disability (describe)		
Dominant Eye (x)	R	L	Intended Use (x)		
Selected Eye (x)	R	L	Person-to-person		
MPD-Monocular Pupillary	Distance - distance vision		With computer		
Reflex Method	R	L	Computer	Model	
Non-reflex Method	R	L	IBM or compatible		
Frame	Bridgesize	Eyesize	Macintosh		
Outer canthus to top of ear	mm	Color	Operating System	Type	
Pantascopic Tilt (x)	2 7 12	Other	PC - Win 95 +		
Ocular Motor Control (x)	Good Fair	Poor	PC - Other		
Date			Mac - System 6 +		
Name (please print)			Order Date		
Tel.#			P.O. # (institutional)		

PAYMENT METHOD	
<input type="checkbox"/> P.O. enclosed	<input type="checkbox"/> Check enclosed

ITEM	DESCRIPTION	QTY	UNIT PRICE	TOTAL
	Prices in USD			

CLIENT NAME AND ADDRESS IF OTHER THAN "SHIP TO"	SUBTOTAL

Shipping & handling	

TOTAL	

Ordered by: _____ Relation to client: _____