



BiPAD Request to Trial in the Operating Room

This is a request for a product for use in trial during surgery. We are happy that you want to trial BiPAD and look forward to your feedback. Please send completed forms to trial.request@bipadsurgical.com

Contact Information:

First Name:	Last Name:	Title:
Email Address:		Phone:
Facility Name		
Shipping Address:		City, State, Zip:

Shipping Information:

Please only fill out if different than the above

First Name:	Last Name:	Title:
Email Address:		Phone:
Facility Name		
Shipping Address:		City, State, Zip:

PO Information:

A PO is required to send product. Please attach a PO to have your trial processed quickly. If BiPAD should follow up with another person for the PO, please provide the contact information here.

Name:	Title:
Phone:	Email:

Billing Information:

Please only fill out if different than the above

First Name:	Last Name:	Title:
Email Address:		Phone:
Facility Name		
Shipping Address:		City, State, Zip:

Trial Details:

Generators Planned for Use:

<input type="checkbox"/> Codman/Malis*	Type/Model:
<input type="checkbox"/> Medtronic/Valleylab	Type/Model:
<input type="checkbox"/> Other: _____	Type:/Model:
<input type="checkbox"/> *Do you need a Y adapter cord for your machine? YES NO	
A Y Adapter is provided complimentary with your trial if needed. If a purchase is made this is yours to keep at no charge. If no purchase is made 30 days after the trial a charge of \$199 will automatically be billed to you unless returned to BiPAD Surgical, 110 Ocean Pkwy, Point Look Out, NY 11569	

Surgeon(s) who will trial:

Surgeon Name:	
Specialty:	
Phone Number:	
Trial Date:	
Surgeon Name:	
Specialty:	
Phone Number:	
Trial Date:	

Signature

Date