BiPAD® SURGICAL
ENHANCED SURGICAL ERGONOMICS

To create innovative solutions that enhance the ability of surgeons to heal.

BiPAD® ACCOUNT REGISTRATION FORM

Thank you for your business, BiPAD® SURGICAL looks forward to partnering with you to enhance the O.R. experience for your staff and patients.

GENERAL:

SPID

Facility Name*:

(Please complete set-up form for each facility accessing contracted pricing)

Facility Website URL:

Federal Tax ID*:

Facility Type:
- ☐ For Profit
- ☐ Not for Profit

Address 1*:

Address 2:

City*:

State*:

ZIP*:

SHIPPING ADDRESS:

Receiving Facility Name*: (if different from facility name)

Attention to:

Shipping Address 1*:

Shipping Address 2:

City*:

State*:

ZIP*:

Contact Name*:

Title:

Phone No.*:

Email*:

State Org/Charter/ID/License/SS#:

PURCHASING DEPARTMENT:

Contact Person Name*:

Title:

Phone No.*:

Email*:

BILLING INFORMATION:

INVOICES Sent Attention to*:

Email*:

Billing Address 1*:

Billing Address 2:

City*:

State*:

ZIP*:

Billing Dept. Director Name:

Title:

Phone No.*:

Email*:

State Org/Charter/ID/License/SS#:

EIN*:

UTILIZATION INFORMATION:

GENERATORS:

☐ Medtronic/Valleylab-compatible No:

☐ Codman/Malis-compatible No:

☐ Other, please specify No:

_____

OF O.R.'s:

In-Patient #: | Out-Patient #: | Off-Site #: | Affiliated Facilities #: | Other #:

O.R. MANAGER:

O.R. Manager Name:

Phone No.*:

Email*:

CENTRAL SUPPLY:

Contact Person Name:

Phone No.:

Email:

Please provide your product review and acceptance protocol: Fax to 516-738-4948

Payment Options: (Payment Terms: Net 30 days, 1.5% finance charge beyond 30 days.)

- [ ] Pay by Purchase Order
- [ ] Pay by Credit Card
- [ ] Pay by check per invoice

(TERMS: Net 30)

Comments

Signature

Date: