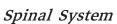
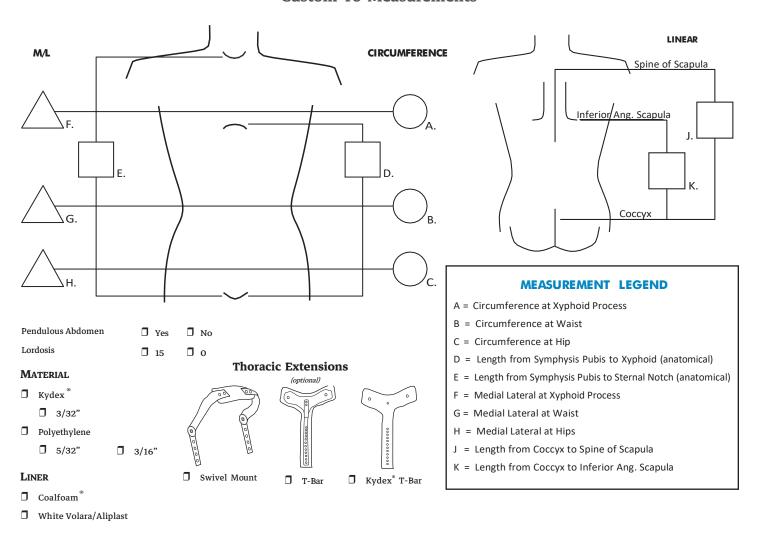
AIR BACK





Custom-To-Measurements



ORDER INFORMATION

Date:	P	.0.#:		
Facility to be billed:				
Ship to Address:				
Phone		Fore		
Phone:		Fax:		
Date Required:				
Ship Via:		On (Date)		
Contact:				
Date:				
Patient Name:				
Age:	Sex:	Height:	Weight:	
Diagnosis:				