Service Order Form

Customer No. (Please complete all information including a	name and phone number)	CONTACT INFORMATION Contact Name	Today's Date: Fitting Date:
Phone # () Fax # (Clinic Name		Contact E-mail	
Sill TO Galdfeess State Z Customer No. Galfferent than HIP TO)	Zip	PATIENT INFORMATION First Name Last Name PATIEN	Middle Initial
hone # () Fax # (company Name ddress ity State			Model Serial #
Dead on Arrival Intermittent Controls Inoperative	* Not availed processor 5 years.	☐ Under warranty ☐ Out of warranty	r -Inv. No. r -issue 6 mth repair warranty r -issue 12 mth repair warranty* ate
Feedback Battery Drain Weak Noisy/Static Distortion Programming Difficulty Volume Control	(Please no "commen instruction regarding exchange)	□ Different side ote in □ Different color ots" □ Different mode ons □ Upgraded proce	l
□ Volume Control □ Battery Door □ Moisture □ Demo Not Working	СОММЕ	ENTS	

Return to: Oticon Medical, 580 Howard Avenue, Somerset, NJ 08873

Phone: 1-888-277-8014 | Fax: 1-732-868-6949 | www.oticonmedical.com/us

