AGTA HOME HEALTH CARE

FAX ORDER FORM

Insured Information Ship To:

Last Name: _____ First Name: _____ Middle Name: _____

Adress: _____ City: _____ Province: _____

Postal Code: _____ Telephone Number: _____ Alternate Telephone: _____

Main Intersection: _____

Insured Information Invoice To:

Insurance Company: _____ Name of Adjuster: _____

Telephone of Adjuster: _____ Ext.: _____ Fax: _____

Company Address: _____ City: _____ Province: _____

Postal Code: _____ Policy/Claim Number: _____ Date of Loss: _____

Name of **Occupational Therapist:** _____ Compant of O.T. (if any): _____

Telephone of O.T.: _____ Ext.: _____ Fax: _____

Signature of O.T.: _____

Qty	Code No.	Description	Rent=R Install=I	Price
			Total:	

Delivery By: _____ **Date Ordered:** _____

Special Instructions: _____

_____

_____

_____

7695 Jane St., Unit #3, Concord, ON L4K 1A8 Phone: 905-760-2482 Fax: 905-760-2498