

Customer Name:

RMA #:

Customer Return/Ship-ToAddress:

City: **State:** **Zip:**

Customer Reference Number:

Contact Name:

Telephone Number:

Facsimile Number:

Email Address:

All goods to be returned to:

LAMONT MEDICAL, Inc.
555 D’Onofrio Drive
Madison, Wisconsin 53719

Tel: **608 827 9000**
 Fax: **608 827 8600**

Customer Instructions:

Call With Estimate Before Proceeding

Notify Us Of Warranty Status

Other:

Product Description:

Part Number:

Model Number:

Serial Number:

Reason For Return: Service Upgrade Other (Provide Details Below)

Describe Problem:

Special Instructions/Comments:

Note: Please use form for only one (1) component/part/assembly

Signature of Person Returning Product:

<u>FOR LAMONT USE ONLY:</u>	IGN #:
	Date Received: