Metalogix Orthopedics, LLC

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Send all Charge Sheets and POs to orders@mlxortho.com or FAX to 833-659-2019

PO NUMBER:

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REP NAME:

REP PHONE:

REP EMAIL:

AFFIX PATIENT LABEL HERE

SURGEON:	HOSPITAL:	DATE OF SURGERY:	SURGERY TYPE:

NURSE NAME (PRINTED):	NURSE SIGNATURE:
REP NAME (PRINTED):	REP SIGNATURE:

BILL TO:	SHIP TO:
ADDRESS:	ADDRESS:
CITY/STATE/ZIP:	CITY/STATE/ZIP:
PHONE/EMAIL:	RESTOCKS NEEDED ☐ BILL ONLY ☐

QTY.	PART DESCRIPTION	PART #	LOT #	PRICE	EXT PRICE
				GRAND TOTAL:	