

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:

DISTRIBUTOR:

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
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GRAND TOTAL: