Prosoma LLC

Prosoma LLC
1932 Drew St, Unit 11
Clearwater, FL 33765
Phone 727-648-2791
Fax 727-221-7725

Sarcotropin IPA Clinic Order Form

Physician / Practitioner Name: Date:

_____ _____

Address:

_____

_____

Phone:

_____

Email Address:

_____

Product: Quantity:

_____ _____

Shipping:

☐ Ground ☐ Second Day Air ☐ Next Day Air

Method of Payment:

_____

Notes:

_____

_____

_____

Signature

Prosoma LLC_____

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Name_____ agrees that ProSoma, LLC can process the MC / VISA / DISC (circle one) card number _____ with expiration date of _____, security code _____, and billing zip code _____ for all requested orders.

The authorizing party also represents and warrants that the above-mentioned credit card is in good standings and has adequate available open credit line to complete such transactions and that the individual or corporation whose name is on the credit card has authorized the above-mentioned transactions.

It is also understood that the individual signing this agreement has full authority to do so.

Agreed to by:

Printed Name:_____ Title:_____

Signature:_____ Date:_____