



P.O. Box 780241  
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 www.truewoundcare.com

## Order Form

### True3 Digital Mattress Systems with Tri-Phasic Technology

To place order: Please email this completed form to [orders@truewoundcare.com](mailto:orders@truewoundcare.com) ( Required Info \* )

\* Order Date: \_\_\_\_\_ \* PO #: \_\_\_\_\_ \* Contact Phone: \_\_\_\_\_  
 \* Name of Customer: \_\_\_\_\_ \* Contact Name: \_\_\_\_\_  
 \* Shipping Address: \_\_\_\_\_  
 \* City, State, & Zip: \_\_\_\_\_ \* Contact Email: \_\_\_\_\_

Order	Item Number	Product Description	Qty
<u>STANDARD 36(in) FULL MATTRESS SYSTEMS</u>			
_____	TTMS-3000	True3 Digital Mattress System-Standard	1 ea.
_____	COVTTD-S	True3 Digital Replacement Mattress Cover-Standard	1 ea.
_____	PUMPTTD-S	True3 Digital Replacement Pump-Standard	1 ea.
_____	MATTTTD-S	True3 Digital Replacement Mattress- Standard	1 ea.
<u>BARIATRIC 42(in) FULL MATTRESS SYSTEMS</u>			
_____	TTDE-3030	True3 Digital EXTRA Mattress System-Bariatric	1 ea.
_____	COVTTD-B	True3 Digital Replacement Mattress Cover- Bariatric	1 ea.
_____	PUMPTTD-B	True3 Digital Replacement Pump- Bariatric	1 ea.
_____	MATTTTD-B	True3 Digital Replacement Mattress- Bariatric	1 ea.
_____	EXTWTTD	True3 Digital System Extended Warranty (add'l 12 mo.)	1 ea.

### Shipping Preferences (Please select your shipping preference below)

_____ Standard Ground Shipping	(3 to 5 business days)
_____ Express Shipping 2nd day	(2 business days)
_____ Express Shipping Overnight	(Next day morning delivery)
_____ Express Shipping Overnight	(Next day afternoon delivery)
_____ Express Shipping Overnight	(Next day morning/Saturday delivery)

If a shipping preference is not selected prior to emailing or calling order, your order will automatically ship Standard Ground.  
 All standard and expedited shipping preferences will be charged to the customer.

**Thank you for choosing True Woundcare, we appreciate your business!**

# Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time by contacting us in writing at info@truewoundcare.com. This authorization will remain in effect until notified otherwise by email.

Credit Card Information				
Card Type:	<input type="checkbox"/> MasterCard	<input type="checkbox"/> VISA	<input type="checkbox"/> Discover	<input type="checkbox"/> AMEX
Cardholder Name (as shown on card): _____				
Billing Address Associated with this Credit Card: _____				
City: _____ State: _____ Zip Code: _____				
Card Number: _____				
Expiration Date (mm/yy): _____				
CVV Number (Visa, Mastercard, Discover- 3 Digit Numeric Number): _____ <b>Number found on back of Credit Card</b>				
CVV Number (American Express- 4 Digit Numeric Number): _____ <b>Number found on front of Credit Card</b>				

By signing this authorization, I, \_\_\_\_\_, authorize True Woundcare to charge my above credit card. I understand that my information will be saved & protected to file for future transactions on my account that exceed the 30-day net terms as well as any monthly reoccurring supply orders you wish to have billed to this card.

\_\_\_\_\_  
Customer Signature

\_\_\_\_\_  
Date