

Extended Warranty Application

PRINT OUT THIS FORM. COMPLETE AND RETURN IT TO BIODEX MEDICAL SYSTEMS

Customer Number: _____

Customer Name: _____

Address: _____

Contact Person: _____

Phone: _____ Fax: _____

Email: _____

Simply complete the Extended Warranty Application, listing the equipment you would like covered. Mail or fax the application to Biodex and we will send you an agreement contract for your review and approval. For further details please call us at 631-924-9000 ext. 2113.

Parts/Labor Part No.	Equipment/Products Description	Serial Number	Contract Price

Once Biodex receives this Application an Extended Warranty Agreement will be sent to you for your final approval. Please be aware that your product(s) are not covered until a final **Extended Warranty Agreement** has been issued, signed and returned

Total _____
Date Offered _____
Date Accepted _____
Payment Plan _____
P.O. Number _____

Authorized Customer Signature

Authorized Biodex Medical Systems Inc. Rep

Date

**Once the form is completed please fax it to Biodex at 631-924-8355
or mail it to: Biodex Medical Systems, Inc 20 Ramsay Road, Shirley, New York, 11967-4704**

BIODEX

Biodex Medical Systems, Inc.