



Specialty Health Products

Written Order

Phone: (800) 343-4950

Fax: (623) 581-8724

www.shpinc.net

CUSTOMER INFORMATION

Name of Applicant:		S.H.P. Customer#:	
Business Name:		Date:	
Address:			
City:		State:	Zip:
Phone:	Fax:	E-Mail Address:	
Scope of Services:			
Professional Qualifications:			
Colon Hydrotherapy Training (Please list all):			
Years In Business:	Malpractice Insurance: Yes: <input type="checkbox"/> No: <input type="checkbox"/>	If Yes Insurance Company Name:	
Colon Hydrotherapy Equipment (list all instruments on premises):			
Other Information:			

PRESCRIPTIVE PRODUCT REQUEST

Hydro-San Plus Device	<input type="checkbox"/>	Other Accessories	<input type="checkbox"/>
Disposable Speculums	<input type="checkbox"/>	Oxygen Concentrator	<input type="checkbox"/>

I certify that all the information on this form is true and correct and understand this prescription is **non-transferable**.

Signed: _____ Date: _____

OFFICIAL USE ONLY

Under my authority as a licensed healthcare provider, I grant written order for the purchase/sale of the products indicated above.

Practitioner's Signature:	License No.:	Date: