

# First Medica

## Repair Authorization Form

Item:  Serial #:   
Date:  /  /  Warranty:  Y / N

Returned by:
<input type="text"/>
Contact Name:
<input type="text"/>
e-mail:
Phone: ( <input type="text"/> ) - <input type="text"/>

Purchased from:	Date: <input type="text"/> / <input type="text"/> / <input type="text"/>
<input type="text"/>	
PO #:	
Contact Name:	
Phone: ( <input type="text"/> ) - <input type="text"/>	

Description of problem:
<input type="text"/>
<input type="text"/>
<input type="text"/>
Note: broken tips are not covered by warranty. Contact your salesperson for a new tip.

<b>To be completed by repair facility</b>	
Problem found:	
<input type="text"/>	
<input type="text"/>	
Estimate:	<input type="text"/>

Estimate accepted by:	Date: <input type="text"/> / <input type="text"/> / <input type="text"/>
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**Please return this form along with your repair. Send to:**  
**First Medica Repairs, 13030 Homer Smith Rd., Piedmont, SD 57769**

- \* First Medica does not provide shipping labels or call tags.*
- \* If the item is out of warranty no work will be done until this authorization form has been returned. If customer does not accept the estimate the item will be returned.*
- \* Do NOT return glass tips or orange shields with light repairs - First Medica will not be responsible for them.*
- \* BE SURE TO INCLUDE YOUR RETURN ADDRESS SO THAT WE CAN SEND BACK YOUR REPAIRED EQUIPMENT**

**\* For repair questions e-mail: [repairs@firstmedica.com](mailto:repairs@firstmedica.com)**