
# Written Order

Phone: (800) 343-4950
Fax: (623) 581-8724
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| 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: | I-ACT Member: Yes: ☐ No:☐ | Malpractice Insurance: Yes: ☐ No:☐ | |
| Colon Hydrotherapy Equipment (list all instruments on premises): | | | |
| Other Information: | | | |

| PRESCRIPTIVE PRODUCT REQUEST | | | |
|---|---|---|---|
| Hydro-San Plus Model A | ☐ | Disposable Speculum Kits | ☐ |
| Hydro-San Plus Model C | ☐ | Additive Accessories | ☐ |

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.

| **Doctor's Signature:** | **Doctor's ID No.:** | **Date:** |
|---|---|---|
| _____ | _____ | _____ |