

Sales Representative's name: _____

Customer Information:

Company/Customer: _____

Contact Name: _____

Address: _____ Suite Number: _____

City: _____ State/Province: _____ Postal Code: _____ Country: _____

Telephone: _____ Cell: _____ Fax: _____

Business Address (if different): _____

Email Address: _____

Payment Information – Please choose one of the following:

Check Visa MasterCard American Express Discover

Down Payment Credit Card Number: _____ Expiration Date: ____ / ____ / ____

Name As It Appears On Card: _____ CVV Code: _____

Billing Address (if different): _____

Monthly Payment Credit Card (if different): _____ Expiration Date: ____ / ____ / ____

Name As It Appears On Card: _____ CVV Code: _____

Billing Address (if different): _____

SSN: _____ - _____ - _____

WellnessPro Pack \$ _____

Extra Accessories _____

Initial Payment: U.S. \$2,000.00

+ Shipping: U.S. \$ _____

+ Accessories: U.S. \$ _____

Total Down Payment: U.S. \$ _____

Financed amount U.S. \$ _____

Authorization:

By signing below, I agree to the terms and conditions of the "15-15 Finance Program" and specifically authorize Electromedical Technologies, Inc. and/or its designee(s) to charge for product(s) in the amount of U.S. \$_____ (indicated as Total Down Payment). I understand that Electromedical Technologies and/or its designee(s) will charge my Credit Card monthly in the amount of: \$100.00 \$150.00 \$200.00 \$_____ until the Financed amount (indicated above) is paid in full.

Print Name _____

Signature _____

Date _____

Order Confirmation:

Telephone me personally at:

Email me at:

For more information on products available through Electromedical Technologies, please see your representative or contact the Corporate Office.

Customer Service: 1.888.880.7888

C-15APP (REV.4 – 02/2019)

MDS-2539