



# PURCHASE ORDER FORM

Name: \_\_\_\_\_

**Postal Address:**  
 \_\_\_\_\_  
**Suburb:** \_\_\_\_\_  
**City/Town:** \_\_\_\_\_  
**Phone:** \_\_\_\_\_

**Delivery Address:**  
 \_\_\_\_\_  
**Suburb:** \_\_\_\_\_  
**City/Town:** \_\_\_\_\_

I would like to purchase:

- \_\_\_\_\_ x **CosaminDS Starter Pack (180 Capsules) @ \$180.00 ea (incl GST)**      \$ \_\_\_\_\_
- \_\_\_\_\_ x **CosaminDS 180 Refill Pack (180 Capsules) @ \$180.00 ea (incl GST)**      \$ \_\_\_\_\_
- \_\_\_\_\_ x **CosaminDS 90 Refill Pack (90 Capsules) @ \$97.50 ea (incl GST)**      \$ \_\_\_\_\_
- plus courier charge**      \$    5.00

**TOTAL**

\$ \_\_\_\_\_

## Payment is by Cheque or Credit card only

1) Attached please find my cheque for \$ \_\_\_\_\_

Mail this order form with your cheque to: **Biocel Health Limited, PO Box 101-865, NSMC, Auckland**

2) My credit card type is     **Amex**       **Diners**       **Visa**       **Mastercard**

My credit card number is:               

Expiry date: \_\_ / \_\_      Name on Credit Card: \_\_\_\_\_

Signed: \_\_\_\_\_

Fax this form to: 09 480 2079, mail to the above address, or order direct phone: 0800 246 235

### Please Note: Goods will not be shipped unless payment has been received.

Further information which will assist us - please tick appropriate details:     Male     Female

Age Group:     20-30     31-40     41-50     51-60     61-70     71-80     80+

Joints Affected:     Hip     Knee     Shoulder     Elbow     Hands     Feet     Spine

Other \_\_\_\_\_

How did you hear about CosaminDS?     GP/Health Professional     Friend/Family     Advertisement

Website     Other \_\_\_\_\_

Name of referring Health Professional? \_\_\_\_\_