Proactive
medical products

STRETCHER PAD ORDER FORM

Date:_____ P.O. Number:_____

Name:_____

Company Name: _____

Address:_____

City:_____ State:_____ Zip:_____

Tel:_____ Fax:_____

Thickness:

☐ 1” ☐ 2” ☐ 3” ☐ 4” ☐ 5”

Sections:

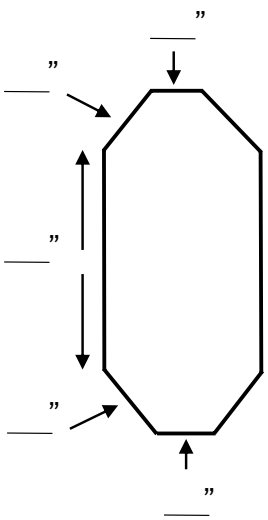
☐ 1 ☐ 2 ☐ 3

Style:

Corners, Head: ☐ Cut-off ☐ Square ☐ Round

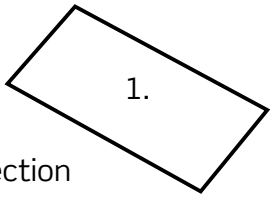
Corners, Foot: ☐ Cut-off ☐ Square ☐ Round

Cut-off Dims:



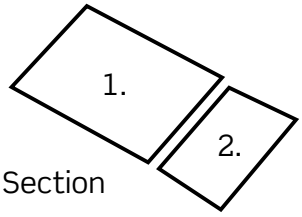
Core Options:

☐ Protekt Ultra ☐ Protekt Basic



One Section

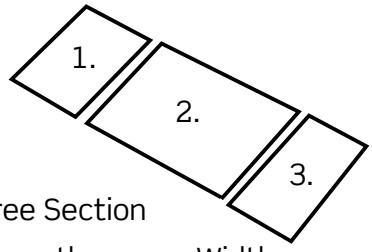
1. Length _____ Width _____



Two Section

1. Length _____ Width _____

2. Length _____ Width _____



Three Section

1. Length _____ Width _____

2. Length _____ Width _____

3. Length _____ Width _____

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