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Authorisation of Resident Orders through Superior Healthcare

THIS FORM MUST BE RETURNED TO SUPERIOR HEALTHCARE WITH ALL FIELDS COMPLETED PRIOR TO GOODS BEING DELIVERED.

CONFIDENTIAL INFORMATION for this purpose only. DATE:

Residents Name:

Facility:

Address: Post Code:

Telephone: Fax:

Authorised By: Applicants Name:

Relationship: Telephone: ()

Address: Post Code:

I/We (the Applicant) hereby approve Superior Healthcare Australia Pty. Ltd. to supply goods to the above individual (the Resident) and I/We (the Applicant) understand that I/We (the Applicant) are liable for all accounts owing for orders placed by the facility on behalf of the above individual (the Resident).

Signature..... Date.....

Print Name.....

If any of the above details change, please contact our office on Ph: (03) 8787 8222 or F: (03) 8787 8333