



# PARKS MEDICAL CORPORATION

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## REPAIR REQUEST FORM

### CUSTOMER INFORMATION

Date: \_\_\_\_\_ PO #: \_\_\_\_\_  
 Name: \_\_\_\_\_ Dept.: \_\_\_\_\_  
 Street: \_\_\_\_\_ Contact: \_\_\_\_\_  
 City: \_\_\_\_\_ Phone: \_\_\_\_\_  
 State: \_\_\_\_\_ Zip: \_\_\_\_\_ Fax: \_\_\_\_\_

Name and phone # of person to approve repair cost:

\_\_\_\_\_ ( ) \_\_\_\_\_

- Begin repairs if the estimate matches the details below and the charges are less than \$500.
- Begin repairs if the charges are less than \$\_\_\_\_\_ (please indicate dollar amount).
- Do not begin repairs without authorization, please call first.

### ITEM(S) TO BE REPAIRED

Model #: \_\_\_\_\_ Serial #: \_\_\_\_\_ RMA # \_\_\_\_\_  
 Model #: \_\_\_\_\_ Serial #: \_\_\_\_\_ RMA # \_\_\_\_\_

The problem(s) is/are:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

### DISINFECT OR STERILIZE EQUIPMENT BEFORE SHIPPING!!!

- This scope may be leaking
- This scope has been disinfected
- This scope has been sterilized

Please keep a copy of the completed form for your records and send a copy along with the equipment to be serviced. Customer pays for the shipping.



This form may be filled out electronically using Acrobat Reader. Just click on the line and type!