

Archiving Clinical Trial Documents - Order Form



Purchasers Details	
Name	
Email	
Phone	

Order Quantity	Cost
1	£9.99
2	£17.98
3	£24.00
4	£28.00
For numbers above this please contact the Ops Director for a quote	

Order	
Quantity	
Total (£)	

Payment
I wish to pay by Credit Card <input type="checkbox"/> Debit Card <input type="checkbox"/> AMERICAN EXP (extra charges will apply) <input type="checkbox"/> Card number <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Start Date <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Expiry date <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Name (as it appears on the card) _____
I wish to pay by Invoice <input type="checkbox"/>
Purchase Order Number <input type="text"/>
Invoices can only be raised when a PO no. is provided

Delivery Address	
Postcode	

Billing/Invoice Address	
Postcode	

For Office Use Only		
Order taken on (date)	Payment taken (date)	Sent (date)