Order Form

Shasme Healthcare

Ordered By: ______________________ Date: ______________________
Telephone: ______________________ Email ______________________
Bill To: ______________________ Ship To: ______________________
City: ______________________ City: ______________________
Province: ______________________ Province: ______________________
Postal Code: ______________________ Postal Code: ______________________

☐ Credit Card: ______________________ Expiration Date: _____ / _____
☐ Check Account Number________________Routing Number____________________Bank Name__________________CK#_____
☐ Money Order

SKU	Title/Description/Variation	Quantity	Price	Subtotal
			Subtotal	
Free Shipping on all Karman Brand Products (Except to Hawaii)	Contact our Representative for Shipping Cost			
To speak to a representative, call: 866-774-8044			**Total**	

Mail To: Shasme Healthcare, Inc.
7235 Scottwood Ave.
Cincinnati, OH 45237—312

Fax To: 866-773-0298 (For Orders Only Please!)

wheelchairsabound.com