RETURN | EXCHANGE FORM

E8-1155 Appleby Line, Burlington, ON L7L 5H9
Tel: (905) 335-7029 Fax: (905) 335-4154
Email: info@premierorthoticslab.com
www.premierorthoticslab.com

CLINIC INFORMATION

Clinic Name: ______________________
Practitioner Name: ______________________
Address: ______________________
City: ______________________
Postal Code: ______________________
Phone: ______________________

PATIENT INFORMATION

Patient Name: ______________________
Age: ______________________
Weight: ______________________
Shoe Size: ______________________
Gender: ☐ M ☐ F

OFFICE USE ONLY

Date ______________________

L/N # ______________________

☐ **SHOE RETURN** ☐ **SHOE EXCHANGE**

FOOTWEAR BEING RETURNED FOR CREDIT OR EXCHANGE MUST BE IN ORIGINAL CONDITION, OTHERWISE EXTRA CHARGES WILL APPLY. SHOE ONLY'S CANNOT BE RETURNED FOR CREDIT.

EXCHANGES

❏ MEN'S ❏ WOMEN'S ❏ YOUTH ❏ WITH ORTHOTIC

FROM: MAKE: ____________ MODEL: ____________ SIZE: ________ WIDTH: ________

TO: MAKE: ____________ MODEL: ____________ SIZE: ________ WIDTH: ________

❏ MEN'S ❏ WOMEN'S ❏ YOUTH ❏ WITH ORTHOTIC

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TO: MAKE: ____________ MODEL: ____________ SIZE: ________ WIDTH: ________

ADDITIONAL INSTRUCTIONS

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