



THE RICHMOND LIGHT COMPANY 2301 FALKIRK DRIVE RICHMOND, VIRGINIA 23236

Toll Free Phone (888) 276-0559 Fax (804) 276-5378 Voice (804) 276-0559

Please print or type:

Mailing Address

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Shipping Address

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone Number: ( ) \_\_\_\_\_ Home ( ) \_\_\_\_\_ Work

Please enter my order for:

- FS40T12UVB-BP 4 foot UVB lamp
- FS72T12UVB-SL 6 foot UVB lamp
- FS72T12UVB-SL 6 foot UVB lamp
- FS72T12UVB-SL 6 foot UVB lamp

Note: There will be a boxing fee for orders of less than three lamps.

Please Choose Method of Shipping

- Freight collect (pay freight at time of shipping)
- Prepay and add freight (Call for a shipping quote)

You will be notified of the shipping company's name and the approximate date of delivery.

Make check payable to **The Richmond Light Company**. (Certified or Cashier's check will speed delivery as there is a two (2) week delay for personal checks.) **Full financial arrangements must be made prior to shipment.**

Please bill my credit card:



Account No. \_\_\_\_\_

Verification No. from back of card: \_\_\_\_\_

Expiration Date: \_\_\_\_ / \_\_\_\_

Signature \_\_\_\_\_

**MEDICARE ELIGIBLE RECIPIENTS** must give their name, date of birth, sex, and Medicare number exactly as it appears on their card.

Medicare No.: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex:  Male  Female

**IMPORTANT!** The **CONDITION OF SALE** form on the reverse side must be completed and a **PRESCRIPTION** for the purchase of the unit, signed by a physician, must accompany your order.

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# CONDITION OF SALE

Ultraviolet light sources distributed by **The Richmond Light Company** are intended solely for use in the treatment of skin disorders. They are not to be used as a tanning device. Using the manual provided, the patient agrees to obtain the required understanding of the use of the unit under the supervision of the prescribing physician. Minor patients for whom this unit is prescribed must be under the supervision of a parent or guardian who understands the proper use of this equipment and assumes full responsibility for the minor.

**CAUTION:** Avoid Overexposure. All persons operating and assisting with the unit must wear **UV Protective Goggles**. All nonessential persons and pets must be removed from the area.

**The Richmond Light Company** assumes no responsibility for the medical or other health related side effects due to use or misuse of ultraviolet light sources that it manufactures. The patient and physician release **The Richmond Light Company** from any and all responsibility for medical complications that may result from the use or exposure to this unit.

The patient agrees to have a general skin examination by the prescribing physician or dermatologist at least once a year.

The patient recognizes and agrees that failure to follow the instructions of the prescribing physician releases the physician and **The Richmond Light Company** from all liability for any negative consequences due to the use of this product.

The purchaser agrees that if ownership of a unit is transferred to another person, it must be done only after notifying **The Richmond Light Company** and through a physician who will prescribe the use of the unit and become responsible for seeing that it is used in the prescribed manner. The purchaser understands that until the subsequent purchaser assumes responsibility for the use of the unit by signing a release form similar to this one, the original purchaser is solely responsible for any negative consequences for the use of this unit. This document should be accompanied by a proper prescription directing the patient to acquire a UV Light Source for the treatment of a skin disorder.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_  
(Patient or Legal Guardian)

## PLEASE TYPE OR PRINT

Physician: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Physician Telephone No.: (\_\_\_\_\_) \_\_\_\_\_

Physician UPIN No.: \_\_\_\_\_