Langer Biomechanics
An OHI Company

Repair Work Order

LAB USE ONLY
Date Received: _____ Incoming Postage: _____
☐ SHOES ☐ L ☐ R ☐ B/L Opened By: _____
☐ NEGATIVE CASTS ☐ L ☐ R ☐ B/L ☐ POSITIVE CASTS ☐ L ☐ R ☐ B/L

ACCOUNT INFORMATION (please print neatly)

Account # _____ P.O. # _____
Practitioner _____
Account Name _____
Phone _____ Fax _____
Street Address _____
City/St/Prov _____
Zip/Postal Code _____

☐ Refurbish ☐ R ☐ L ☐ B/L
☐ Recover to original specs ☐ R ☐ L ☐ B/L

Repair devices as stated here: _____

☐ Please have PAR Call me.
Charge to: ☐ Master Card ☐ VISA ☐ AmEx ☐ Discover
_____
Expiration Date _____ Signature _____

PATIENT INFORMATION

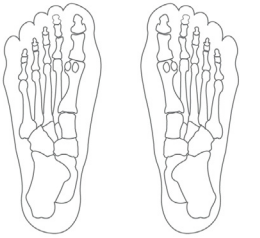
Last Name _____
First Name _____
Serial Number **(Very Important Information)**
_____
Is patient covered by PROTECT® Program? ☐ Yes ☐ No
If yes, enclose PROTECT WORK REQUEST AUTHORIZATION.

POSTING VALUES

	RIGHT	LEFT
RF	_____	_____
FF	_____	_____

☐ ADJUST ARCH ☐ Lower ☐ R ☐ L ☐ B/L
☐ Raise ☐ R ☐ L ☐ B/L

1/8" Standard unless otherwise requested
☐ Balance as indicated _____
☐ Balance as drawn
1 2 3 4 5 R L B/L



R **#1010** L

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