

NEW ACCOUNT REGISTRATION

After filling in, please email to order@ossdesign.com

SURGEON

Name _____ Title _____
Phone (office) _____ Phone (mobile)* _____
E-mail _____

CONTACT PERSON

Name _____ Title _____
Phone (office) _____ Phone (mobile)* _____
E-mail _____

* **Required field:** Your mobile phone number will only be used for identity verification

HOSPITAL/CLINIC

Hospital/Clinic name _____
Department _____

SHIPPING ADDRESS

Street _____
City _____ State _____
ZIP code _____ Country _____

HOSPITAL CONTACT PERSON

Name _____ Title _____
Phone (office) _____ Phone (mobile) _____
E-mail _____

INVOICE DETAILS