

HANDPIECE WORK ORDER

DR'S NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

TELEPHONE: _____ FAX: _____

CONTACT PERSON: _____

For free First-Class U.S. Postal Service delivery to our office, please fill out this form completely and place equipment to be repaired and top copy of this form inside provided Business Reply Mail box and seal. Give it to your regular postal delivery person. Please sterilize all equipment before sending for service. All warranty claims must be accompanied by a copy of the original invoice. Thank you for using Diversified Dental Sales. *We appreciate your business!*

HANDPIECE MAKE	SERIAL NUMBER	REPAIR AS NEEDED	ESTIMATE	WARRANTY
1. _____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. _____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. _____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. _____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. _____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. _____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. _____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. _____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

ADDITIONAL INSTRUCTIONS OR COMMENTS: _____

IN OFFICE USE ONLY
Emp: _____ Approved by: _____ Date: _____



Dental Equipment, Supplies & Technology ■ Sales, Service & Solution Provider
10 Technology Drive, #7 ■ Setauket, NY 11733 ■ Tel: 1-888-689-2871 ■ Fax: 631-689-8104

(PLEASE PHOTOCOPY AND RETAIN COPY FOR YOUR RECORDS)

1. Please print this page.
2. Please cut sheet in half on dotted line to separate Handpiece Work Order from Prepaid Mailing Label and instructions.
3. Please fill out Handpiece Work Order completely and be sure to include telephone number.
4. Put your repair in a bubble mailer or box along with Handpiece Work Order.
5. Please cut out Prepaid Mailing Label on dotted line and attach to top of box.
6. Place mailing box in U. S. Post Office Box or give to your Letter Carrier.

This label is only valid for air-driven highspeed and slowspeed handpieces.

NO POSTAGE
NECESSARY
IF MAILED
IN THE
UNITED STATES

From Dr. _____

BUSINESS REPLY MAIL
FIRST-CLASS MAIL PERMIT NO. 65 SETAUKET NY

POSTAGE WILL BE PAID BY ADDRESSEE

Diversified Dental Sales
 10 Technology Drive
 Suite 7
 Setauket, NY 11733-9706

FIRST CLASS