Visionary Optics

uniquely specialized contact lenses

DEFECTIVE DIAGNOSTIC FITTING SET RETURN FORM

Clear Form | Save | Print

INVOICE #: _____ ACCOUNT #: _____

RETURNED BY: _____ DATE: _____

[First & Last Name]

ADDRESS: _____

_____

EMAIL: _____

PHONE: _____

REASON FOR RETURN

Complete Description of Reason for Return:

_____

_____

_____

_____

_____

_____

_____

Patient Contact (Insertion) ☐ YES ☐ NO Patient Injury ☐ YES ☐ NO

TO RECEIVE CREDIT, ALL DEFECTIVE DIAGNOSTIC FITTING SET RETURNS MUST HAVE THIS FORM AND A COPY OF THE INVOICE INCLUDED WITH THE RETURN. PLEASE PRINT & INCLUDE WITH DEFECTIVE DIAGNOSTIC FITTING SET.