

KAZOO ORDER FORM:

Name (Print) _____ Date _____

Company _____

Shipping Address _____
Street City State Zip

Email _____

Phone(____) _____ Fax(____) _____

Quantity (min 10) _____

Cost: _____
X \$2.00

Sales Tax _____
Determined by state

Shipping _____
Determined by number ordered
We will email you a shipping quote

Total _____

Email or mail registration form to: info@posturalrestoration.com
Postural Restoration Institute
5255 R Street
Lincoln, NE 68504

Method of payment:
 MasterCard Visa Discover AMEX

Credit Card # _____ Exp. Date _____ Security Code _____

Billing Address _____
Street City State Zip

Name on card _____

Signature _____