PO Box 75449
Oklahoma City, Oklahoma 73147
mmo.monicaf@gmail.com

# ALPS HEARING AID ORDER FORM

CLIENT NAME AND ORGANIZATION_____

SHIP TO: _____

ADDRESS: _____

_____

_____

PHONE/EMAIL: _____

**ALPS (model, quantity, color):**
Erika I: quantity_____ color_____
Erika ND: quantity_____ color_____
Erika Power: quantity _____ color_____
Erika ND Power: quantity _____ color_____
Bone Conduction Hearing Aid: quantity_____

**User Manuals**: English:_____ Hindi:_____

**Spare Parts***:* BTE eartips:_**S,M,L:**_____ Earhooks:_____ Battery doors:_____

Please note: The shipping fees will be added to your invoice.
The $45 international bank wire fee will be added to your invoice.

**Method of payment**: **bank wire**:_____The bank wire information for Mayflower Medical Outreach will be provided. ___**check:** ____ ___ Payable to Mayflower Medical Outreach (with IHHAPP entered in the memo section). Mail to Mayflower Medical Outreach, PO Box 75449, Oklahoma City, OK 73147
_____**Credit card**:_____Online payment to www.mayflowermedical.org In the Donations section, access the IHHAPP field. *** a surcharge of 2.5% will be added to cover the cost of the credit card fee.

**Questions and/or comments**: _____

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