PHONAK
life is on

PHONAK PROFESSIONAL COURTESY DISCOUNT PROGRAM REQUEST FORM

If you or another eligible individual (see Program details for eligibility) are interested in the Phonak Professional Courtesy Discount Program, please complete this form and return it with your order to your Phonak Sales Representative or Inside Sales Representative for acknowledgement and processing. For ITE Orders, please include order form with request form. Please print. Missing information may delay processing.

Hearing Professional/Colleague at the Practice Information	
Name:	
Account Number(1):	Title:
Practice Street Address(2):	
City, State, Zip Code(2):	
Telephone Number(2):	
Immediate Family Member Information (if products are not for you)	
Name:	
Street Address:	
City, State, Zip Code:	
Telephone Number:	
Relationship to hearing professional/practice colleague:	
Hearing Professional Information (if not you)	
Name:	
Practice Street Address:	
City, State, Zip Code:	
Telephone Number:	
Please list the products you are ordering under this program:	
The hearing professional/colleague at the practice agrees that the above information is true and complete. **Hearing professional/colleague at the practice**: Name (PRINT): _____ Name (Sign): _____ Date: _____/_____/_____	
Once the request has been acknowledged by Phonak Sales Management, your order will be placed and sent to the practice address above.	
Sales Management Acknowledgement: Signature: _____ Date: _____/_____/_____	

Date Completed_____

(1) Phonak account number must be set up to implement Program.
(2) For VA hearing professionals, please provide home address and phone number.