

**RETURN AUTHORIZATION REQUEST FORM**

TODAY'S DATE: \_\_\_\_\_

CUSTOMER #: \_\_\_\_\_

CUSTOMER NAME: \_\_\_\_\_

INVOICE #: \_\_\_\_\_

INVOICE DATE: \_\_\_\_\_

ITEM DESCRIPTION: \_\_\_\_\_

\_\_\_\_\_

QUANTITY BEING RETURNED: \_\_\_\_\_

WAS PRODUCT OPENED OR USED? YES  NO

REASON FOR RETURN (CHECK ALL THAT APPLY):

EXPIRED  DATE&LOT #: \_\_\_\_\_

DAMAGED:

MANUF. PACKAGING	<input type="checkbox"/>	* RECV'D WRONG PRODUCT	<input type="checkbox"/>
OUTSIDE CARTON	<input type="checkbox"/>	*ORDERED WRONG PRODUCT	<input type="checkbox"/>
LOOKS REPACKAGED	<input type="checkbox"/>	*NOT THEIR ORDER	<input type="checkbox"/>

RETURNING FOR REPAIR

PRODUCT IS DEFECTIVE

DID MANUFACTURER SEND REPLACEMENT? YES  NO

\*EXPLANATION (this must be completed):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

WAS REPLACEMENT SENT: YES  NO

IF NO, WHY? \_\_\_\_\_

\_\_\_\_\_

FORM COMPLETED BY: \_\_\_\_\_

**AUTHORIZED SIGNATURE:** \_\_\_\_\_

**\*All RA labels are sent in the MAIL. Please allow 5 business days to process.**

**\*Form MUST be completely filled out. Failure to do so will delay RA being issued.**

Tri-State Dental