



DELIVERY AUTHORIZATION FORM

Patient's Name:

If I am not home, please do not leave delivery.

I understand that if I do not authorize Charm Medical Supply to leave my delivery or if I do not give an alternative delivery option below that I will not be sent a shipment until the following month.

As an alternative, you may also schedule a pick-up at our Pembroke MA location if you miss your delivery.

OR

If I am not home, I authorize Charm Medical Supply to leave the delivery as described below:

X

Signature of Patient, Parent or Guardian

Date