

SaJune Medical Center

954 Lake Baldwin Lane

Orlando, FL 32814

Ph: 407-478-9797

Fax: 407-478-9798

www.sajune.com

AutoOrder 15% off Supplements

Name: _____

Shipping Address: _____

City/State/Zip: _____

Credit Card Type/Exp Date: _____

Billing Zip Code: _____

Credit Card Number: _____

Supplement(s) desired: _____

Orders are processed the 1st and 15th of each month.

Please process my order on: _____ of each month.

For local patients please allow at least four days to receive orders.

(If the date falls on a weekend or holiday orders will be processed on the following business day)

I authorize SaJune Medical Center to charge my credit card and ship the above supplement(s) each month on the above date. Shipping will be added to your order, usually \$5.00 - \$10.00 additional.

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

To make any changes to your AutoOrder at any time please email to azink@sajune.com or fax 407-478-9798. Please give 24 hours notice from your next order processing date.