Think Twice

IT'S BETTER YOU KNOW, BEFORE YOU GO

Form for calibration or to send faulty device

Customer (shipping address / return)

Name: ____________________ Name of the company: ____________________

Street: ____________________________

City: ____________________ Postal Code: ____________________

Telephone: ( ) ____________

Email address: ________________________

Place device was purchased: __________________________

Date of Purchase: ______________________

Date of the last calibration: _________________Does the device give good results? Yes ____ No _____

Instructions

Only include payment if you wish to calibrate your device

1. Include this form fully completed.
2. Only send your device, keep all attachments.
3. Include the payment of $39.95 for calibration.
4. Ship the device to the following address: Think Twice, Inc.
   P.O. Box 1831
   Bellevue, WA 98009-1831

6. Your device will be verified in a period of 10 business days.

Payment by credit card

Modes of Payment: Credit Card _____ Visa . _____ MasterCard _____

Check ____

Credit Card Number: ________________________ Date of expiration: ______________

Name as it appears on the credit card: ______________________

Signature: ____________________

(Include the credit card billing address, if it is different from the address of shipping / return address.)

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For office use only

Date of the calibration: ________________________

Technician: ________________________

Payment received: ________________________