

# SCHOTTLANDER RETURNS REQUEST FORM

**PLEASE COMPLETE THIS FORM WITH ALL RELEVANT INFORMATION TO ENSURE THAT YOUR REQUEST CAN BE COMPLETED AS SWIFTLY AS POSSIBLE**

Other than for returns under complaint, items must be received by us unused, in non-tampered packaging, within one month of invoice date and be accompanied by this form (or a photocopy).

**PLEASE ENSURE THAT PRODUCTS ARE PACKED IN A BOX SUFFICIENT FOR RETURN**

Returns reference \_\_\_\_\_  
 (Please obtain from Customer Service on Freephone 0800 97 000 79)

Account No. and account name \_\_\_\_\_

Contact name and telephone No. \_\_\_\_\_

Invoice No. and invoice date the goods were despatched \_\_\_\_\_

Product name / product code being returned	Quantity returned

Reason for return (please tick box)	Further action required
Goods received damaged <input type="checkbox"/>	Please refund my account
Goods ordered in error* <input type="checkbox"/>	Please send me a replacement (same product)
Wrong goods despatched <input type="checkbox"/>	
First time 30 day return (UK only) <input type="checkbox"/>	Please send me a replacement (different product) - please specify which product and quantity:
For repair <input type="checkbox"/>	
For service <input type="checkbox"/>	

If item is for repair/service or does not meet the specifications, please describe the fault:  
 \_\_\_\_\_  
 \_\_\_\_\_

If the item(s) being returned have been used during treatment of patients please confirm that they have been disinfected in accordance with BDA and Department of Health guidelines and state the method used (Health & Safety Work Act 1997 and the Post Office Act 1969).

Sterilised using autoclave  Sterilised by dry heat

Treated by cold sterilant/disinfectant  (please state which product was used) \_\_\_\_\_

I confirm that the item(s) have either not been used during treatment with patients or have been treated as specified above.

Signed \_\_\_\_\_ Position \_\_\_\_\_

\*Subject to a handling charge of 20%