Customer No.: _____ Ship To Code: _____

Name _____

Address _____

Address 2 _____

City _____ State _____ Zip Code _____

Shoe Return Form

PHONE: 800-556-5572

FAX: 262-242-9300

In order to receive full credit, a copy of this form must be filled out completely and included in shoe box.
Failure to submit this form may result in a $10 restocking fee.

Patient Name:	Order # or Invoice # :

Return Info:

Style Name	Color	Size	Circle Width	Circle Pairs of Inserts
			N M W XW	0 1 2 3

PLEASE DO NOT REORDER SHOES ON THIS FORM!
Replacement orders need to be completed on the shoe order form and faxed to 262-242-9300 or online at www.drcomfortdpm.com

Reason for Return - Please Check all that apply !

Customer Changed Mind ☐	Duplicate Order ☐	Defective Item ☐
Wrong Color ☐	Wrong Size ☐	Wrong Style ☐
Shipped to Wrong Doctor ☐	Damaged in Transit ☐	Repair/Adjustments ☐

Additional thoughts on the return:

_____

_____

_____

_____

_____

PLEASE DO NOT REORDER SHOES ON THIS FORM!
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