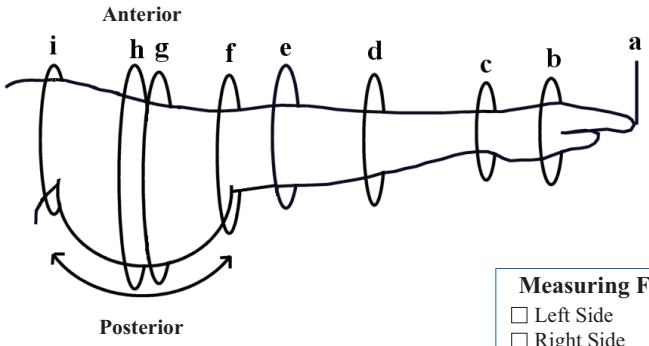
The ReidSleeve People
Peninsula BioMedical INC.

Toll-free fax: 866-808-7538

Asymmetrical Upper Extremity Supplemental Measuring Form

FDA Class 1. CFR 880.5160.

Photographs are REQUIRED for all asymmetrical orders



MEASURE WITH ARM HELD STRAIGHT OUT FROM BODY

Measuring For:
- ☐ Left Side
- ☐ Right Side

Measuring In:
- ☐ Inches
- ☐ Centimeters

Fill In All Circumferences:

		TOTAL	Anterior	Posterior
(Axilla)	i			
(Widest part of Protuberance)	h			
(Bicep)	g			
(Area just before Protuberance)	f			
(Elbow)	e			
(Forearm)	d			
(Wrist)	c			
(Palm)	b			

Fill In All Medial Lengths:

a-i _____ Fingertips to Axilla
c-i _____ Wrist to Axilla
c-h _____ Wrist to Widest Part of Protuberance
c-g _____ Wrist to Bicep
c-f _____ Wrist to Area Just Before Protuberance
c-e _____ Wrist to Elbow
c-d _____ Wrist to Forearm
c-a _____ Wrist to Fingertips
_____ Axilla to Protuberance
_____ Length of Protuberance Contoured

- ☐ Include Precise Gauge
- ☐ Include Carry Case

Custom Options:
- ☐ Axilla cut-out
- ☐ Zipper
- ☐ Classic Glove design
- ☐ D-rings
- ☐ Shoulder Extension (NEW)
- ☐ Shoulder Extension (OLD)
- ☐ Include Precise Gauge
- ☐ Include Carry Case
- ☐ Foam Density: Light
- ☐ Foam Density: Medium
- ☐ Foam Density: Heavy

Custom Colors - Classic Only:
■ Default color is Black
- ■ Shell: _____
- Accent: _____
- ■ Liner: _____

Special Requests:

Patient Information

Name or Order# _____ Height _____ Weight _____

I authorize release of my name to Peninsula BioMedical Inc. for identification purposes related to manufacturing of my custom garment.

_____ _____
Signature (patient) Date

For Peninsula BioMedical Use Only
Finished goods inspected for quality compliance to above specifications:

By _____ Date _____

Bill To

PO Number _____
Name _____
Address: _____
_____
Phone: _____

Ship To
(if different than billing info)

Name _____
Address: _____
_____
Phone: _____

Method of Shipping
(default method is 3-Day or Ground if destination is on the West Coast)

☐ Ground ☐ 3-Day ☐ 2-Day ☐ Overnight ☐ Other _____

I understand that this is a custom made garment and the garment will be made to the measurements specified above. Peninsula BioMedical, Inc. is not responsible for measuring errors. Should the garment need to be returned for alterations due to measurement errors, the fee for alterations are the responsibility of the undersigned.

_____ _____
Signature (guarantor of measurements) Date

If credit terms have been provided, I agree to pay the total amount on the invoice within the terms on file with Peninsula BioMedical. All invoices are **due and payable within 30 days or per terms of written agreement** of the date listed on the invoice. Any invoice over 30 days or the written terms on file is considered delinquent and a **1.5% late fee** will be **assessed monthly**. Should any invoice become delinquent I understand the account may be placed on a C.O.D. basis, a prepay basis or the account may be suspended.

_____ _____
Signature (purchaser) Date