Miller Medical Supplies Return Form

Company/Surgery Name:		**Contact Name:**	
		Tel No:	
Date Returned:		**Email:**	
Miller Delivery/Invoice Number:		**Customer Purchase Order: (if applicable)**	

Item(s) To Be Returned:

Reason(s) For Return:

Postage Refund Approved: (Proof of Postage/Receipt Required)	Yes ☐ No ☐	**Approved By: (Must Be Provided)**	
Credit/Refund Required:	Yes ☐ No ☐	**Replacement Required:**	Yes ☐ No ☐

Miller Medical Supplies Internal Use:

Miller Date Received:	
Miller Received & Checked By:	
Credit Approved:	Yes ☐ No ☐
Re-Stocking Fee Applied:	Yes ☐ No ☐
Replacement Sent: (if applicable)	Yes ☐ No ☐

Miller Medical Supplies Returns Address:

Miller Medical Supplies Ltd
RETURNS DEPARTMENT
Phoenix House
9 Turner Street
Newport
South Wales

NP19 7BA

Tel: 01633 213366 / Fax: 01633 213203
Email: customercare@millermedicalsupplies.com
www.millermedicalsupplies.com

Please complete this form in full. Failure to complete the form in full may result in your return being rejected, or being subjected to a restocking fee.