



PRODUCT REGISTRATION FORM

Register **ONLINE** at www.invacare.com - or -
Complete and mail this form

Name _____

Address _____

City _____ State/Province _____

Zip/Postal Code _____

Email _____ Phone No. _____

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here

Invacare Model No. _____ Serial No. _____

Purchased From _____ Date of Purchase: _____

1. Method of purchase: (check all that apply)

☐ Medicare ☐ Insurance ☐ Medicaid ☐ Other _____

2. This product was purchased for use by: (check one)

☐ Self ☐ Parent ☐ Spouse ☐ Other _____

3. Product was purchased for use at:

☐ Home ☐ Facility ☐ Other _____

4. I purchased an Invacare product because:

☐ Price ☐ Features (list features) _____

5. Who referred you to Invacare products? (check all that apply)

☐ Doctor ☐ Therapist ☐ Friend ☐ Relative ☐ Dealer/Provider ☐ Other _____

☐ Advertisement (circle one): TV, Radio, Magazine, Newspaper ☐ No Referral _____

6. What additional features, if any, would you like to see on this product?

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7. Would you like information sent to you about Invacare products that may be available for a particular medical condition? ☐ Yes ☐ No

If yes, please list any condition(s) here and we will send you information by email and/or mail about any available Invacare products that may help treat, care for or manage such condition(s):

8. Would you like to receive updated information via email or regular mail about the Invacare home medical products sold by Invacare's dealers? ☐ Yes ☐ No

9. What would you like to see on the Invacare website?

10. Would you like to be part of future online surveys for Invacare products? ☐ Yes ☐ No

11. User's Year of birth: _____

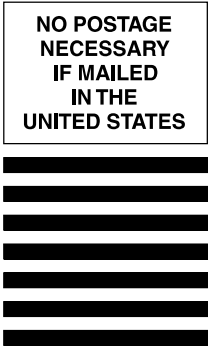
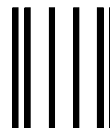
If at any time you wish not to receive future mailings from us, please contact us at Invacare Corporation, CRM Department, 39400 Taylor Parkway, Elyria, OH 44035, or fax to 877-619-7996 and we will remove you from our mailing list.

To find more information about our products, visit www.invacare.com.

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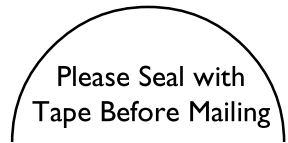


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