



American Society of  
Ophthalmic Registered Nurses  
Specialists in Eye Care

# Product Order Form

Please print form, complete, and

**Send to :** ASORN, Dept. 34095, PO Box 39000, San Francisco, CA 94139  
fax 415/561-8531 or phone 415/561-8513

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Email: \_\_\_\_\_

	Member Price	Non-Member Price	Quantity	Amount
<b>Standards of Ophthalmic Clinical Nursing Practice</b>	\$15	\$20	_____	\$ _____
New ASORN Logo Pin	\$10	\$10	_____	\$ _____
Retired ASORN Logo Pin	\$ 5	\$ 5	_____	\$ _____
CRNO Pin (Must be a CRNO)	\$10	\$10	_____	\$ _____
			CA Residents add sales tax (9.5%)	\$ _____
			Postage & Handling	\$ 1.00
			<b>TOTAL DUE</b>	<b>\$ _____</b>

## Method of Payment

Check One:

Check or Money Order Enclosed

Visa or Mastercard (please specify)

Charge Card# \_\_\_\_\_ Exp. Date \_\_\_\_\_

Cardholder (print or type) \_\_\_\_\_ Signature \_\_\_\_\_

Cardholder Address (if different from above):

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

Please allow 2-3 weeks for delivery

For office use only. Do not write in this space.

Payment Received \$ \_\_\_\_\_

Date Rcvd. \_\_\_\_\_ \$ \_\_\_\_\_

Check # \_\_\_\_\_ \$ \_\_\_\_\_

Date Shipped \_\_\_\_\_

4100-0511 (products)

4519-0511 (publications)

2210-0000 (CA sales tax)

batch # \_\_\_\_\_