

ABCSP Letterhead Order Form

RADIOLOGY CLINIC: _____
CONTACT PERSON: _____
MAILING ADDRESS: _____
CITY: _____ POSTAL CODE: _____
PHONE: _____ FAX: _____ EMAIL: _____

	Quantity
ABCSP letterhead with clinic logo	_____ (package(s) of 500 sheets)
Envelopes	_____ (box(s) of 500 envelopes)

Please Clinic:

<input type="checkbox"/> Amiha Diagnostic Imaging	<input type="checkbox"/> Blair Stubbs & Associates Radiology Inc.
<input type="checkbox"/> Breast Centre Radiology Inc.	<input type="checkbox"/> CAMIS Ltd.
<input type="checkbox"/> Camrose & Area Mammography Centre	<input type="checkbox"/> Calgary Women's Imaging Centre
<input type="checkbox"/> Canada Diagnostic Centres _____	<input type="checkbox"/> CML HealthCare _____
<input type="checkbox"/> Devon X-Ray Clinic	<input type="checkbox"/> EFW Radiology
<input type="checkbox"/> Insight Medical Imaging	<input type="checkbox"/> Medical Imaging Consultants
<input type="checkbox"/> Peace Diagnostic Imaging Ltd.	<input type="checkbox"/> Peace River Community Health Centre
<input type="checkbox"/> Pureform Diagnostic Imaging Clinics	<input type="checkbox"/> Radiology Associates Inc.
<input type="checkbox"/> Radiology Consultants Associated	<input type="checkbox"/> Screen Test
<input type="checkbox"/> The X-Ray Clinic at Northgate Centre	
<input type="checkbox"/> Other _____	



Please allow 30 business days for order and delivery

PLEASE FAX YOUR ORDER TO:
ALBERTA BREAST CANCER SCREENING PROGRAM (ABCSP)
FAX: (403) 355-3289
Inquiries call toll free: 1-866-727-3926

September 2009