VWR Thermometer Order Form

Name of Clinic/Physician: _____

Address: _____

City: _____ **Postal Code:** _____

Contact: _____ **Phone #:** _____

Upon receipt of this form by WDG Public Health, you will receive your new VWR thermometer.
An invoice for **$130.00** will be mailed to your office with payment instructions.

PublicHealth
WELLINGTON-DUFFERIN-GUELPH
Stay Well.