



# FAR INFRARED HEALTH INC.

2620 Regatta Dr., Suite #102, Las Vegas, NV 89128  
Toll Free phone: 1-888-327-9663

Return Authorization #: \_\_\_\_\_

Today's Date: \_\_\_\_\_

Returns Department: 2225 - 21331 Gordon Way, Richmond, BC V6W 1J9 Canada

E-Mail: [inquiry@farinfraredhealth.com](mailto:inquiry@farinfraredhealth.com)  
[www.farinfraredhealth.com](http://www.farinfraredhealth.com)

## RETURN AUTHORIZATION FORM

Please fill this form out completely!

Sold To:	
Name:	
Address:	
City:	
State:	Zip:
Country:	
Phone:	Fax:
Email:	

Method Of Original Payment:
<input type="checkbox"/> Visa <input type="checkbox"/> MasterCard <input type="checkbox"/> PayPal <input type="checkbox"/> Check <input type="checkbox"/> M/O
Name on Card: _____
Credit Card#: Last 4 digits of your card..... _____
Expiry Date: _____

Original Invoice #: \_\_\_\_\_ or Original Shopping Cart #: \_\_\_\_\_  
Copy of Invoice / Shopping Cart Order Included?:  Yes  No

Product Code	Description	Reason for return

### Explain your request ie: what you want - items you want exchanged etc.

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Merchandise may be returned within 90 days from the date of order in original packaging material..

There is a 15% administration fee on all refunds. No fees for exchanges.

Original shipping and handling and return postage charges will not be refunded. Manufacturer defective merchandise will be exchanged if returned within 90 days from the date of order. No refunds for Manufactured Seconds, Discounted or Bargain items.

For Office Use Only:	
Received By: _____	Comments:
Items Condition: _____	
Re-Sellable?: <input type="checkbox"/> Yes <input type="checkbox"/> No	Date Material Received:
Date Replacement issued: _____	
Date Refund Issued: _____	

All returns MUST be accompanied by this form.