

## Warren M. Levin MD

**PLEASE PRINT**

### BUYER INFORMATION

<b>NAME:</b>	<b>FIRST</b>	<b>MIDDLE</b>	<b>LAST</b>	<b>HOME PHONE #:</b>
				(    )
<b>ADDRESS:</b>	<b>STREET</b>	<b>CITY</b>	<b>STATE</b>	<b>ZIP</b>
				<b>CELL PHONE #:</b>
				(    )

- |  |                                      |                     |
|--|--------------------------------------|---------------------|
| <b>I would like to purchase the following CD(s):</b>           | <i>One CD:</i>                       | <i>\$15.00 each</i> |
| <input type="checkbox"/> Hypoglycemia                          | <i>Two CDs:</i>                      | <i>\$14.00 each</i> |
| <input type="checkbox"/> Informed Consent on Chelation Therapy | <i>Three CDs:</i>                    | <i>\$13.00 each</i> |
| <input type="checkbox"/> Allergy/Addiction                     | <i>Four CDs:</i>                     | <i>\$12.50 each</i> |
| <input type="checkbox"/> Estrogen                              | <i>Five + CDs:</i>                   | <i>\$12.50 each</i> |
| <input type="checkbox"/> Asthma                                | <i>Purchase 5, receive 6th FREE!</i> |                     |
| <input type="checkbox"/> Candida                               | <i>(shipping extra)</i>              |                     |

### CREDIT CARD PAYMENT AUTHORIZATION

I, \_\_\_\_\_ hereby authorize Warren M. Levin, MD and/or the staff at 407 Church Street N.E., Suite E, Vienna, Virginia 22180 to charge my credit card for the purchased indicated above.

**NAME:** (as it appears on credit card): \_\_\_\_\_

- MasterCard**     
  **Visa**     
  **American Express**     
  **Discover**

Credit Card Number: \_\_\_\_\_      Expiration: \_\_\_\_\_      Security Code: \_\_\_\_\_

Signature: \_\_\_\_\_      Date: \_\_\_\_\_

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

City: \_\_\_\_\_      State: \_\_\_\_\_      Zip Code: \_\_\_\_\_

*Please mail this completed form to:*  
*Dr. Warren M. Levin*  
*407 Church Street NE, Suite E*  
*Vienna, VA 22180*

*Or fax to:*  
*703-255-0316*