Warranty

Thank you for purchasing the DPL™ Therapy unit.

Please complete and return this form within 30 days to activate your product warranty.

Name _____

Address_____

City _____

State/Province _____

Zip/Postal Code _____

E-Mail _____

Telephone _____

Date of Purchase _____

Serial Number _____

How did you order the DPL™ System?

TV Internet Store Called Direct Other

What skin condition(s) are you treating with your unit?_____

How would you rate your ordering experience? Excellent Good Fair Poor

What made you choose the DPL™ System?

_____

_____

DPL™ Therapy
Deep Penetrating Light

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