Signia's direct-to-patient repair service

We’re here to help.

Name: (First / Last) ______________________________________

Email: ______________________________________

Home Address: ______________________________________

Phone Number: ______________________________________

Model: ______________________________________

Serial Number(s): ______________________________________

Provider Clinic Name: ______________________________________

Provider Address: ______________________________________

Provider Phone Number: ______________________________________

Reason for Repair Request: ______________________________________

By sending this directly to WSA you are authorizing a one-time repair with all terms and conditions that apply.

Signature: ______________________

Date: __________