



MedCaster Application Questionnaire

PLEASE FAX THIS COMPLETED FORM TO: 1-517-686-1072

| | |
|------------------|----------------|
| Company: _____ | Phone: _____ |
| Address: _____ | Fax: _____ |
| City: _____ | Email: _____ |
| State/Zip: _____ | Contact: _____ |

Application: Hospital Clean room Pharmaceutical Food equip/service
 Furniture Laundry Other (please specify) _____

Describe Unit: (i.e. bed, cart, patient lift, etc.)

Total Weight of Unit Empty: _____ (lbs.) **Total Weight of Unit Loaded:** _____ (lbs.)

Environmental Conditions: (i.e. temperature, chemical, flooring, etc)







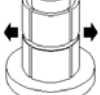
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|--|--|--|
| Caster Ratio per Unit: _____ Rigid _____ Swivel _____ Total Lock _____ Direction Lock | Total Number of Units: X _____ = | Total Number of Casters: _____ Rigid _____ Swivel _____ Total Lock _____ Direction Lock |
|--|--|--|

Wheel Size: _____ **Wheel Bearing:** Precision Delrin Roller Plain

Wheel Material: Non-marking Rubber Polyolefin Polyurethane Antistatic
 Nylon Phenolic Santoprene Neoprene

Fork Construction: Steel Stainless Steel Aluminum Plastic

Special Requirements: (i.e. load height, wheel/fork colour, etc.)

| | | | | | | |
|---|---|---|---|--|---|---|
| Fittings: (please circle) | These fittings are available in a variety of sizes, or custom fittings can be designed to suit your application. Please contact us for more details, including specific dimensions. | | | | | |
|  |  |  |  |  |  |  |
| Hollow Rivet | Top Plate | Cylindrical Stem | Square Stem | Grip Ring Stem | Threaded Stem | Expanding Adapter |
| If you know the approximate dimensions required for your fitting, enter them below. | | | | | | |
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