

OmniPod Patient Acknowledgement Form

This form must be completed and returned **with your prescription** to Diabetic Promotions before your order for the OmniPod Starter Kit or Infusion Sets can be processed.

Patient Name: _____

Patient Address: _____

Patient Phone: _____

Physician Name: _____

Physician Address: _____

Physician Phone: _____

I acknowledge that the OmniPod Insulin Management Starter Kit (Diabetic Promotions item #36583) and the OmniPod Integrated Infusion Sets (Diabetic Promotions item #36584) **cannot be returned** to Diabetic Promotions for a refund or credit. I understand that the manufacturer of these items, Insulet Corporation, has a limited warranty on these items. I also understand that there is information regarding these items, including any warranty, available online at www.myomnipod.com.

Patient (or Guardian) Signature: _____

Please mail completed form and prescription to:

Diabetic Promotions
P.O. Box 5400
Willowick, OH 44095-0400