



DIVINE LIFE

Return Authorization Form

Order Number:	
First Name:	
Last Name:	
Phone Number:	
Email:	
Street Address:	
City:	
State:	
Zip:	
Reason for Return:	<input type="checkbox"/> Defective Product <input type="checkbox"/> Difficulty Swallowing <input type="checkbox"/> Expired Product <input type="checkbox"/> Package/Bottle Tampered <input type="checkbox"/> Health Related <input type="checkbox"/> Not Satisfied <input type="checkbox"/> Taste/Odor
Please Provide a Brief Statement:	