

Name and Address	
Email address	
Contact phone number	
Date problem reported (DD/MM/YY)	
Date of Purchase (DD/MM/YY)	
Proof of purchase must be attached	
Medication Cup Serial Number	
Date of Production (DD/MM/YY) (date on med cup)	
Medication Cup Colour (grey/green)	
Description of problem	
Issue Reported by Customer Other (comment)	
What is being nebulised (solution 1)	
What is being nebulised (solution 2)	
What is being nebulised (solution 3)	
Estimated Number of Uses (total)	
Nebulized Volume (ml per session)	
Please return with medication cup to: BreathEazy, 154 Worcester Road, Malvern, WR14 1AA	