Name and Address	
Email address	
Contact phone number	
Date problem reported (DD/MM/YY)	
Date of original purchase (DD/MM/YY) - please also provide proof of purchase	
Has this product already been replaced under warranty and if so when?	
Medication Cup Serial Number	
Medication cup date of manufacture (DD/MM/YY)	
Medication Cup Colour (grey/green)	
Description of problem	
What is being nebulised (solution 1)	
What is being nebulised (solution 2) - optional	
What is being nebulised (solution 3) - optional	
Estimated Number of Uses (total)	
Nebulized Volume (ml per session)	
Please complete ALL yellow compulsory fields and email back to support@breatheazy.co.uk along with proof of purchase	