

Please Scan and Email
Completed Form to:
returns@tophealthsource.com



Please Mail Form to:
Calotren
Attn: Returns Department
100 N 1st Street
Union City, TN 38261

Request Return Form

Please fill out entire form below. Please use blue or black ink and PLEASE USE PRINT.

First Name: _____

Date: _____

Last Name: _____

Order #: _____

1 How would you like to request to handle your return/exchange?		
Store Credit	Return	Exchange

2 Did you place the order by phone or on our website? (Circle one)	Phone	Website
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3 Reason for Return? _____

4 How long did you take Calotren? _____

5 Please explain your method for taking Calotren. _____

6 Do you have any medical problems? _____

7 Are you taking any medications? _____

8 Did you take the yeast test before starting Calotren? (Circle one)	Yes	No
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9 Do you have joint pain? (Circle one)	Yes	No
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10 Did you speak with your Calotren consultant? (Circle one)	Yes	No
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11 Please list any known allergies. _____

12 Total unopened bottles of Calotren you have to return? (Capsules or Liquid) _____

13 Do you need to return supplements other than Calotren?	Yes	No
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14 How many unopened bottles of other supplements do you have? _____