## HEALTH GUARD HAND SANITIZER

## DSR SPIFF APPROVAL FORM

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| Promotion Details |
| * **$5 hanging allowance** for the New Health Guard™ Hand Sanitizer Dispensers

Manual BK/BK - SS001BK31HS, Manual WH/WH - SS001WH33HS, No Touch M-Fit WH/WH - MS016WH33HS and No Touch WH/WH – NS011WH33HS* **$5 per case DSR spiff** on the 70% gel (7441 or 7444) and 70% foam (71041 or 71044)
* **$2 per case DSR spiff** on the 62% foam (68841 or 68844)
 |
| Distributor Information |
| PROMOTION SHOULD BE LAUNCHED WITH A DSR SALES MEETING. AT THE CONCLUSION OF THE PROMOTION, PROOF OF DELIVERY (POD) FOR PRODUCT MUST BE SENT TO KUTOL WITHIN 30 DAYS FROM PROMO EXPIRATION DATE. POD MUST ACCOMPANY THIS FORM. |
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| Distributor Name: |       | Key Contact: |       |
| Address: |       |
| Promotion Dates: |       through       | (90 days max, unless pre-authorized by Kutol) |
| Kutol Sales Rep: |       | Rep. Company Name: |       |
| Proposed Sales Meeting Date: |       | # of DSR’s: |     | Samples/Literature Ordered: Yes [ ]  No [ ]  | Date: |       |
|  |
| Targeted End Users |
| End User Name: |
|       |       |
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| KUTOL SIGNATURE FOR PROMOTION APPROVAL |
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|  |  |
| Kutol Territory Manager Signature  | Date |

## HEALTH GUARD HAND SANITIZER DSR SPIFF REIMBURSEMENT FORM

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| PAYMENT INFORMATION |
| AT THE CONCLUSION OF THE PROMOTION, ENTIRE FORM & PROOF OF DELIVERY (POD) FOR PRODUCT MUST BE RETURNED TO KUTOL WITHIN 30 DAYS FROM PROMO EXPIRATION DATE. EMAIL TO TERI BASHAM’S ATTENTION. TBASHAM@KUTOL.COM |
| Distributor Name: |       | Key Contact: |       |
| Address: |       |
| Kutol Sales Rep: |       | Rep. Company Name: |       |
|  |
| End User Name: |       |
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|  |
| Total # of Dispensers (ea): |       | X  | $ 5.00 | **=** | $       |
| Total # of Cases of Soap (7441, 7444, 71041 & 71044): |       | X | $ 5.00 | **=** | $       |
| Total # of Cases of Soap (68841 & 68844): |       | X | $ 2.00 | **=** | $       |
| Total Amount to be Paid: | $       |
|  |  |
|       |       |
| Rep. Signature (for Credit Memo approval) | Date |
| **PAY TO INFORMATION** |
| **[ ]** Please reimburse by credit memo to the distributor. (Double click on boxes to check.) |
| **[ ]** Please reimburse by check – **Information below is required for Tax purposes.** |
|  Is the Payee Incorporated? Yes **[ ]** No **[ ]**  | Federal Tax ID # (SSN): |       |
|  Payee Name: |       | Phone No.: |       |
|  Mail Check to the Attention of: |       | Company Name: |          |
|  Check Mailing Address: |       |
|  City: |       | State: |       | Zip: |       |
|  |
| **All fields are required. Incomplete forms will be returned and payment will not be issued. Checks will be processed at the end of the month.** |
| **FOR INTERNAL USE** |
| Approved for payment at Kutol by: |  | Date |  |