SonicTechnology

Quality and Innovation since 1981

SuperEar®

	SE5000	SE7500	SE9000HP
			
HEADPHONES			
STEREO HEADPHONES INCLUDED	YES	YES	YES
STEREO EARBUDS INCLUDED	YES	YES	YES
OPTIONAL HEADPHONES AVAILABLE	YES	YES	YES
STEREO EARBUDS AVAILABLE	YES	YES	YES
SOUND			
AMBIENT SOUND GAIN	50+ dB	50+ dB	50+ dB
VOLUME CONTROL WHEEL	On Unit	On Unit	On Unit
MAXIMUM OUTPUT	107 dB	107 dB	107 dB
FREQUENCY RANGE	100-14000 Hz	100-14000 Hz	100-14000 Hz
FREQUENCY SELECTOR SWITCH	NO	NO	YES
POWER			
ON/OFF SWITCH	On Unit	On Unit	On Unit
AUTOMATIC SHUT-OFF	NO	YES	NO
BATTERIES	1 AAA	2AAA	2 AA
BATTERY LIFE	Up to 30 Hours	Up to 80 Hours	Up to 40 Hours
RECHARGEABLE	NO	NO	YES
CHARGING CUBE AND CABLE	NO	NO	YES
EXTRA FEATURES			
UNIT WEIGHT	3 Ounces	3 Ounces	3 Ounces
SWIVEL MICROPHONE	YES	NO	NO
CARRYING CASE	NO	YES	NO
BELT/POCKET CLIP	YES	YES	YES
WARRANTY	3 Year	3 Year	3 Year
FACILITATE COMPLIANCE			
ACA AND ADA	YES	YES	YES
CMS MDS 3.0	YES	YES	YES
SANITARY EAR-PAD COVERS AVALIABLE	YES	YES	YES
PRICE	**$59.95**	**$69.95**	**$99.95**

For customer reviews, demonstrations, company, and product history: www.sonictechnology.com

Interested in Hospital Direct Programs? Call us today!

Complete the ORDER FORM on the reverse side, then choose your favorite method to contact us:

Fax: (530)272-4257
Mail: P.O. Box 539, Grass Valley, CA 95945

Email: info@sonictechnology.com
Call: 1-800-247-5548 (530) 272-4607

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FAX TO: (530) 272-4257

SuperEar® ORDER FORM

☐ **Please Send:**

Quantity	Product	Price
_____	SE5000 – SuperEar® Standard	$59.95
_____	SE7500 – SuperEar® Plus	$69.95
_____	SE9000HP – SuperEar® Rechargeable	$99.95
_____	SE-HP – Replacement Headphones	$12.95
_____	EPC100 – 50 pairs Disposable Sanitary Ear Pad Covers	$20.00
_____	EPF200 – 10 pairs Replacement Foam Ear Pad Covers	$12.95

Shipping Charges apply to all purchases:

1-9 items	10-39 items	40+ items
$8.95	$14.95	Actual price

Total $ _____

Facility Name (if applicable): _____

Name: _____ Title/Position (if applicable): _____

Address: _____

City: _____ State: _____ Zip: _____

Visa/MC/AE #: _____ Exp. Date: _____

☐ Check enclosed PO# (if applicable)* _____ *with approved credit application

E-mail: _____

Telephone: _____ FAX: _____

☐ **Please Contact Me:** ☐ **E-mail** ☐ **Phone** ☐ **FAX**

☐ **I am interested in the Hospital Direct Program, and would like more information.**

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