FORESTADENT®

GERMAN PRECISION IN ORTHODONTICS

Return form for medical devices

Customer no.*: _____ Name: _____

Order no.*: _____ Batch*: _____ Quantity*: _____ Piece/PACK

Article description: _____

Delivery bill no:* _____ Delivery date: _____

*Compulsory field – must be filled in

Due to legal regulations and especially for the protection of our employees, we require a signed „decontamination certificate“ for every return shipment. Please ensure that this is completed and signed and enclosed with **every product return** (complaint / repair / other reason for return). If this document or a comparable confirmation is not received, we reserve the right to clean, disinfect and sterilize the goods at a batch or return them to the sender. Pack the products in such a way that there is no risk of injury to our personnel in the incoming goods department during unpacking.

Reason for return

☐ Return of unopened product packaging due to incorrect order

☐ Complaint – please fill in „Reason for complaint“ on page 2

☐ Other: _____

Contact for queries

Name: _____

Phone number: _____

Email: _____

Signature: _____

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Proof of decontamination

We hereby confirm that

- ☐ the package was not opened and the return was made within 30 days after order
- ☐ the medical device(s) enclosed with the letter has/have not come into contact with blood, tissue or other body substances/fluids and that hygienic safety can be confirmed.
- ☐ the medical device(s) enclosed with this letter has/have come into contact with blood, tissue or other bodily substances/fluids during use and has/have been disinfected, cleaned and sterilized in accordance with the applicable hygiene requirements of medical devices and the specifications of disinfected, cleaned and sterilized.

  Information on disinfection, cleaning and sterilization:
  - ☐ Disinfection and cleaning was done manually. Agent used: _____
  - ☐ Disinfection and cleaning was done by machine
  - ☐ Steam sterilization (5 min. at 134°C)
  - ☐ Other method (please specify): _____
- ☐ Medical device(s) enclosed with the letter could not be decontaminated!
  → Justification: _____
- ☐ medical device(s) enclosed with the letter has/have been used on patients with a prion disease.

With the following signature we confirm the correctness of the information given above.

_____ _____

Date Signature (and name in block capitals)

Reason for complaint

Appearance

☐ before starting treatment ☐ during the production

☐ during the therapy in the practice ☐ outside the practice, intraoral

Details:

If you have any questions, please contact:

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Westliche Karl-Friedrich-Straße 151 · 75172 Pforzheim
Phone: 07231-4590 · info@forestadent.com

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