**RETURN VERIFICATION FORM**

**FA1244: Palindrome Hemodialysis catheter Inter-lumen Leakage PLEASE COMPLETE THIS FORM IN ITS ENTIRETY**

Date:

Name of Person Completing this Form: Title:

Direct Phone #: Email:

**How did the account purchase this product?**

**Direct from Medtronic: From a Distributor:**

**Customer Contact Details**

**PLEASE EMAIL OR FAX THIS ACKNOWLEDGEMENT TO:**

rs.ranordic@medtronic.com

Denmark +45 3248 1801

Finland +358 (0) 20 728 1201

Norway +47 6710 3210

Sweden +46 (0) 8 568 585 01

Hospital Name:

Account #:

Address:

City:

Zip Code:

 **Department:**

Contact Person at Point of Collection:

Opening Hours:

**Return Goods Authorization (RGA) #**: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** (please include once received from Customer Service)

**No Inventory (Please check):**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Item Code** | **Invoice or Despatch Note (if available)** | **Lot Number** | **Quantity** | **Case or Each** |
|   |  |   |   |   |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|   |  |   |   |   |

Information for the courier: Number of parcels to collect:

Weight: < 45kg > 45kg

**By signing this form, I confirm that I have read and understand the Urgent Field Safety Notice from Medtronic regarding Chronic Hemodialysis Catheters regarding FA1244 dated June 2022.**

**I also agree to further distribute and communicate this important information from this letter to those whom I have distributed any of the Chronic Hemodialysis Catheters noted in this letter.**

(Signature Required)

* Please fax or email this form back to Medtronic within 10 days using the contact details at the top of this form.
* Customer Service will contact you directly to organise return of affected products and credit will be given for returned products.
* Please don’t send the goods back before having received the return documentation.