Medtronic
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URGENT MEDICAL DEVICE Field Safety Corrective Action

Devon™ Light Glove

VERIFICATION FORM

PLEASE COMPLETE THIS FORM IN ITS ENTIRETY

[Please insert date the form was sent]

Customer Contact Details	Medtronic Contact Details
Hospital Name: **Covidien/Medtronic Account Number:**	**To:** [*please insert name*]
Collection Address: **Department:** Street: City: Postal Code: Contact Person at Point of Collection: Opening Hours:	**Address:** [*please insert Medtronic address*]
Telephone:	**Telephone:** [*please insert Medtronic telephone number*]
Fax:	**Fax:** [*please insert Medtronic fax number]*
E-mail:	**E-mail:** [*please insert contact e-mail address*]

Please list the quantity of affected product at your facility, if you have **no** inventory, please tick the box below.

No Inventory (Please check): ☐

Item Code	Invoice or Despatch Note (if available)	Lot number	Quantity (Eaches or Boxes) Please specify

Medtronic

Please complete this form and return it to Medtronic even if you have no affected inventory

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 specific production lots of the Covidien Devon™ Light Glove issued dated January, 2017

Customer Name: (Please Print)	**Signature:**	**Date:**

- Please fax or email this form back to Medtronic within 10 days using the contact details referenced 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.
- **This action is being taken with the knowledge of the [add local Competent Authority].**