




Product Return Form

* Please fill in all the blanks marked with an asterisk (*). They are required information

* Please attach the X-RAY for the further research purposes

* Return Date			Issued No. (DEUTSCHE OSSTEM)			
* Dr's Name			* Dealer Name (Sales Person)			
* Product Name	* Product Code		* Lot #		Q'ty	
* Reason for Product Return	Implant <input type="checkbox"/> No Primary Stability <input type="checkbox"/> No Osseointegration <input type="checkbox"/> Peri-Implantitis <input type="checkbox"/> Item Complaint (Non-Conformance) <i>(Please state more detailed in the field "Details")</i> <input type="checkbox"/> etc. : _____ <i>(Please state more detailed in the field "Details")</i> <input type="checkbox"/> Package sealed (Not Used)		Prosthetic & Tools <input type="checkbox"/> Abutment fracture <input type="checkbox"/> Screw fracture <input type="checkbox"/> Screw loosening <input type="checkbox"/> Item Complaint (Non-Conformance) <i>(Please state more detailed in the field "Details")</i> <input type="checkbox"/> etc. : _____ <i>(Please state more detailed in the field "Details")</i> <input type="checkbox"/> Package sealed (Not Used) <i>* Prosthetic parts and Tools (Drills, KITs) will not be exchanged unless there is a item non-conformance problem.</i>		Details : 	

Date

Signature