OCUTECH®

Product Service/Adverse Response Form

Please complete for service/repair and include with returned product

1 SERVICE REQUESTED BY: ☐ Customer/Patient ☐ Prescriber

Patient Name:

Prescriber (Doctor) Name:

Prescriber Practice Name:

Address:

City:	State:
Zip:	Country:
Phone:	Fax:

Email:

2 OCUTECH PRODUCT TO BE SERVICED:

Product name:	Date Product Purchased:

☐ Inspect, clean and adjust:

☐ Describe repair needed:

☐ **Was there an injury to the user as a result of this incident? No☐ Yes☐ If yes, request Incident Report Form.**

☐ Request estimate prior to repair ☐ Authorize to proceed with repair

3 RETURN PRODUCT TO: If different from above address

Name:

Address:

City:	State:
Zip:	Country:

Phone:

☐ In U.S. - domestic ground ☐ In U.S. - 2nd day rush ☐ In U.S. - overnight-next day

☐ International (Out of U.S.) Ships by DHL.

4 AUTHORIZATION: ☐ VISA ☐ MasterCard

Card #:	Exp. Date:	Code #:

Name on Credit Card:

Signature:	Date:

SHIP YOUR OCUTECH® TELESCOPE TO:

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OFFICE ONLY - Date Rcvd:_____ Rcvd By _____