



# Product Return Form

*\* Please fill in all the blank 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	<b>Implant</b> <input type="checkbox"/> No Primary Stability <input type="checkbox"/> No Osseointegration <input type="checkbox"/> Peli-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)	<b>Prosthetic &amp; Tools</b> <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>	<b>Details :</b>