

PROSTHETICS PRODUCT RETURN FORM

Date:	
Clinic:	
Contact Name:	Contact Number:
Item code/s of products being returned:	
Period Product has been in use:	
Our Invoice number:	Your PO number <i>(if applicable)</i> :
Reason for return:	
1. Product not required	
<input type="checkbox"/> Incorrectly ordered	<input type="checkbox"/> Patient rejection
<input type="checkbox"/> Incorrect item received	<input type="checkbox"/> Other: _____
2. Product Faulty	
Patient Details: First Name:	Surname:
Please provide detailed description of fault:	
Additional Information:	
Has a replacement been received?	
<input type="checkbox"/> No	<input type="checkbox"/> Yes (Please provide invoice or PO): _____

Please detach here and place this address label on the outside of your package:

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Returned Goods
Össur Australia Prosthetics
26 Ross Street,
North Parramatta, NSW 2151