ÖSSUR
LIFE WITHOUT LIMITATIONS

PRODUCT RETURN FORM

Össur -F Product Return Form Rev 4

CUSTOMER & ORDER DETAILS

CLINIC: _____ DATE: _____

INVOICE NUMBER: **SIAT** _____

YOUR PURCHASE ORDER NUMER *(if applicable)*: _____

CONTACT NAME: _____

PHONE NUMBER: _____ EMAIL: _____

ITEM CODE/S OF PRODUCTS BEING RETURNED AND QUANTITY:

PERIOD PRODUCT HAS BEEN IN USE? ☐ UNUSED ☐ _____ (DAYS/MONTHS/YEARS)

REASON FOR RETURN

☐ INCORRECTLY ORDERED
☐ INCORRECTLY INVOICED/RECEIVED
☐ PATIENT REJECTION
☐ PATIENT NO SHOW
☐ DID NOT FULFILL CUSTOMERS NEED
☐ PRODUCT FAULT

Please answer the below questions for Product Fault

PATIENT NAME: _____ PATIENT AGE: _____ PATIENT APPROX. WEIGHT: _____

ACTIVITY LEVEL: ☐ VERY HIGH ☐ HIGH ☐ MEDIUM ☐ LOW

WAS THERE AN INJURY AS A RESULT OF THE FAULTY ITEM? ☐ YES ☐ NO

IF YES, WAS MEDICAL INTERVENTION REQUIRED? ☐ YES ☐ NO

WAS THE PRODUCT USED IN SPORT ACTIVITY? ☐ YES ☐ NO

WHAT HAPPENED/HOW DID THE PRODUCT FAIL?

WHAT WAS THE USER DOING WHEN THE ISSUE/FAILURE OCCURRED?

IS THE PRODUCT BEING RETURNED?

☐ YES ☐ NO

IF YES, METHOD OF RETURN:

☐ COURIER ☐ REP COLLECTION

HAVE YOU SENT/ATTACHED A PHOTO OR VIDEO?

☐ YES ☐ NO

ADDITIONAL NOTES

- PLEASE SEND COMPLETED FORM TO CUSTOMERCARE.AU@OSSUR.COM TO OBTAIN A RETURNS AUTHORISATION
- ONCE ASSESSED, A CREDIT WILL BE APPLIED TO YOUR ACCOUNT FOR ALLOCATION
- IF A REPLACEMENT IS REQUIRED, A NEW PURCHASE ORDER IS TO BE RAISED