SPECIALTY MEDICAL SYSTEMS

ISO 9001:2015 Quality Managed Company **www.smsendo.com**

1911 Broadway ~ Kansas City, MO 64108 ~ Phone (800)-945-4767 ~ Fax (816)-472-4767

REPAIR REQUEST FORM

CUSTOMER INFORMATION

Date: _____ PO#:_____ RMA# if applicable: _____

Facility: _____ Department: _____

Address: _____City: _____State: _____ Zip: _____

Name of contact person to receive repair estimate: _____

How would you like to be informed of the repair estimate? **Circle choice, provide contact:**

Phone: _____Fax:_____Email:_____

ITEM TO BE REPAIRED

Mfg. & Model # _____ Serial #: _____

- Was a death or injury associated with the use of this product? NO __YES__ If yes, describe the injury that occurred:

  _____

- Did the malfunction occur during treatment or therapeutic procedure? (circle one) TREATMENT - THERAPEUTIC
- Did the product malfunction or not perform as intended? NO__ YES__ If yes, describe how the product malfunctioned or not performed as intended. Include the reason for the repair here:

  _____

  _____

  _____

Due to Regulatory Requirements – Please provide reprocessing method

___Cidex OPA ___Glutaraldehyde ___Other:_____

__Medivators __Steris__ J&J __Custom Ultrasonics __Other:_____

DISINFECT OR STERILIZE EQUIPMENT BEFORE SHIPPING!

☐ **This scope may be leaking**

☐ **This scope has been High Level Disinfected**

☐ **This scope or item has been grossly decontaminated only**

☐ **THIS ITEM HAS NOT BEEN DECONTAMINATED**

Signature: _____ Print Name: _____