Phoenix Medical Devices 800-689-9892	**Return Material Authorization (RMA) Request Form**		
Doc No.: **05-13-002**	Process Owner: **Quality Assurance Manager**	Revision: **A**	**Page 1 of 1**

Fax to: 949-266-5928

OR

Mail to: 620 Newport Center Dr., Newport Beach, CA 92660

Please supply information in Section 1. Section 2 is for entering your reason for return.

We ask you to please provide as much information as possible in Section 1. There are both boxes and blank lines in Section 1. The Section 1 boxes are for required information and the lines are for optional information. We will need, at a minimum, the information in the boxes to be completed before we can process the RMA request.

Please fax or mail the completed form to the fax number listed above or to our corporate office address above.

SECTION 1 Customer Name: _____

Phone No.: _____ Ext. Fax No.: _____

Device Model No.: _____ Serial No.: _____

Physician Name: _____ Physician Ph. No.: _____

Condition for which device was prescribed: _____

_____

SECTION 2 - Please describe your reason for returning the product(s): -

This SECTION for PMD use – please do not write in this section

Date Rec'd_____ Assigned to:_____ RMA issued: Yes ☐ No ☐

RMA No.: _____