Phoenix Medical Devices	Customer Feedback Form		
Doc No.: **05-06-001**	Process Owner: **Quality Assurance Manager**	Revision: **B**	**Page 1 of 1**

Fax to: 949-266-8126

OR

Mail to: 2458 Alton Parkway, Irvine, CA 92606

Please supply information in Section 1. Section 2 is for entering the details of your feedback.

We ask you to please provide as much information as possible in Section 1. Anonymous feedback must be discarded. We will verify customer, serial number and product information in the course of processing your feedback. You have our promise that all information will be maintained in strict confidence in compliance with HIPAA regulations. We also promise that your information will never be used for marketing purposes or shared with any other persons or organizations. 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.

SECTION 1 Patient Name: ☐

Phone # : ☐ Fax # :_____ Cell No # :_____

Device Model: ☐ Serial No.: ☐

Physician Name: ☐ Physician Phone # :_____

Condition for which device was prescribed: _____

_____

SECTION 2 - Please describe your feedback here: - attach another sheet if you need more space

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

Date Rec'd_____ Assigned to:_____ Entered into TLM?: Yes ☐ No ☐