INTERNATIONAL AUTHORIZATION FOR RETURN AND EXAMINATION OF MEDICAL DEVICE(S)

I am returning the explanted device(s) to the Mentor Product Evaluation Department. I authorize Mentor to examine, and if necessary, alter the condition of the device(s) as may be necessary for the purpose of safety and to facilitate the evaluation of the device(s).

I have advised my patient, and my patient agrees, that I am returning the device(s) to Mentor for evaluation.

Ensure compliance to Local Data Privacy Regulations prior to adding any patient details.

Mentor may retain possession of the explanted device(s) and save and/or perform destructive testing to the device(s) as deemed appropriate by Mentor.

_____
Patient Name, Patient Initials
or Patient Identifier

_____
Physician's Name

_____
Physician's Signature

_____
Date (DD-MON-YYYY)

Ship to:
C.G. Laboratories, Inc.
2449 Bob White Drive
Granbury, TX 76049
USA