INCIDENT REPORT

INFORMATION

This document must be filled out completely in case of any problem that occurs in the device, any accident that may occur, any injury, or any negative impact on the performance of the device.

COSTUMER INFORMATION		
COMPANY NAME		
ADRESS		
CONTACT PERSON	NAME	
	E-MAIL	
	PHONE	

PRODUCT INFORMATION	
ARTICLE NO.	
DESCRIPTION	
LOT NO. / SERIAL NO.	
QUANTITY	

INCIDENT INFORMATION		
DESCRIPTION OF INCIDENT		
DATE OF INCIDENT		
PLACE OF INCIDENT		
HAS ALREADY BEEN REPORTED TO ANOTHER AUTHORITY?	YES☐	NO☐
HAVE PEOPLE BEEN HARMED?	YES☐	NO☐
ADDITIONAL INFORMATION		

I declare that the information I have provided is correct.

X

NAME

PLACE

NEXOR MEDICAL GMBH
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