

## Implant Registration Form

Artivion's Privacy Policy:

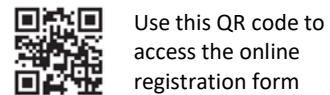
[www.artivion.com/privacy-policy](http://www.artivion.com/privacy-policy)

Place Patient Record Label Here

**This device is required to be tracked under Federal Regulations. Please complete the Implant Registration Form online at [www.artivion.com/ImplantRegistration](http://www.artivion.com/ImplantRegistration) or complete the below form and return to Artivion, Inc.**

\*Please complete this form as fully as local law allows and promptly return to Artivion, Inc.

Return to:  
Artivion, Inc.  
Device Tracking Department  
1655 Roberts Blvd NW  
Kennesaw, GA 30144 USA  
Phone: +1 (888) 427-9654  
Email: [devicetracking@artivion.com](mailto:devicetracking@artivion.com)



<b>Device Information</b> (Select all that apply) <input type="checkbox"/> Implant <input type="checkbox"/> Not Used <input type="checkbox"/> Explant		Anatomical Implant Position _____		Today's Date (YYYY/MM/DD): _____  Date of Service (YYYY/MM/DD): _____	
<input type="checkbox"/> SN OR <input type="checkbox"/> LOT Serial Number   Lot Number		<input type="checkbox"/> REF Catalogue Number		Use-by Date	
<b>Additional Device</b> <input type="checkbox"/> N/A <input type="checkbox"/> Implant <input type="checkbox"/> Not Used <input type="checkbox"/> Explant   Anatomical Implant Position: _____					
<input type="checkbox"/> SN OR <input type="checkbox"/> LOT Serial Number   Lot Number		<input type="checkbox"/> REF Catalogue Number		Use-by Date	
<b>Patient Information</b>			Check if applicable: <input type="checkbox"/> Date of Death: _____ <input type="checkbox"/> Patient Refusal to Release Information		
Name (Last, First) or Patient ID#:			Gender: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Not Indicated		
MRN:	Date of Birth: (YYYY/MM/DD)	Telephone:	Email:		
Mailing Address:					
City:	State/Province:		Zip/Postal Code:	Country:	
<b>Hospital Information</b>					
Hospital Name:			Telephone:		
Mailing Address:					
City:	State/Province:		Zip/Postal Code:	Country:	
<b>Implanting/Explanting Surgeon</b> <input type="checkbox"/> Check if address is the same as above					
Surgeon Name:			Telephone:		
Mailing Address:					
City:	State/Province:		Zip/Postal Code:	Country:	
<b>Follow-up Physician</b> <input type="checkbox"/> Same as Surgeon <input type="checkbox"/> Check if address is the same as above					
Physician Name:			Telephone:		
Mailing Address:					
City:	State/Province:		Zip/Postal Code:	Country:	
Comments:					
Name: _____ Contact phone or email: _____					