**URGENT MEDICAL DEVICE FIELD SAFETY NOTICE RESPONSE FORM**

**Medfusion® 3500 and 4000 Syringe Infusion Pump**

**Business Name**

**Address 1**

**Address 2**

**Address 3**

**Address 4**

**City, State, Postal Code, Country**

Please acknowledge receipt of the accompanying Urgent Medical Device Field Safety Notice by completing andreturning this Response Form to OUS-SmithsMedfusion@sedgwick.com within 10 days. The Response Form must be completed and returned to Smiths Medical’s representatives at Sedgwick even if you have no affected devices in your possession.

**DISTRIBUTORS – Please provide a copy of this Response Form and the accompanying Field Safety Notice to all of your customers to whom you distributed affected devices and complete the For Distributors Only table at the bottom of this page.**

**Please review the statements below and check the appropriate box:**

[ ] I do **NOT** have affected devices in my possession. *Proceed to sign acknowledgement below*

[ ] I have affected devices in my possession, and **I choose to update** my affected devices. *Smiths Medical will contact you to arrange updates.*

[ ]  I have affected devices in my possession, and I choose to **NOT** update the affected devices.

**I certify that I have read and understand the information in the attached Correction Notice.**

|  |  |  |
| --- | --- | --- |
| **Name and Title (Please Print)** | **Signature and Date** | **Facility Name and Address\***  |
|  |  |  |
| **Email Address** | **Telephone Number** |
|  |  |

\*If you are submitting a response form for multiple locations, please include the address for each facility you are responding for on the form or in an attachment.

**For Distributors Only**

**I have identified and notified my customers that were shipped or may have been shipped this product**

Distributor Name, Address, Email and Phone Number

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