# CUSTOMER RETURN AUTHORIZATION FORM

## CUSTOMER DETAILS

<table>
<thead>
<tr>
<th>Company Name:</th>
<th>Address1:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Address2:</td>
</tr>
<tr>
<td>City:</td>
<td>State:</td>
</tr>
<tr>
<td>Telephone No:</td>
<td>Zip Code:</td>
</tr>
</tbody>
</table>

## ITEM DETAILS

<table>
<thead>
<tr>
<th>Device Serial No.</th>
<th>Patient Contact (Y/N)*</th>
<th>Model/Device</th>
<th>Injector (Cartridge) Type &amp; Batch#</th>
<th>Doctor</th>
<th>Reason for Return</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

If more than 10 lenses are being returned please attach a list of, or photocopies of all serial numbers being returned.

## SHIPPING DETAILS

<table>
<thead>
<tr>
<th>Date Shipped</th>
<th>Shipped Via (CARRIER)</th>
<th>No. Cartons</th>
<th>Total Weight (in lbs)</th>
<th>AWB NUMBER</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Send completed Return Authorization form along with device(s) to Lenstec Customer Service at the address above.

*Complete Page 2 for all devices with Patient Contact.*
## CUSTOMER RETURN AUTHORIZATION FORM

**EVENT SPECIFICS:** (Please check all boxes that apply to this event)

<table>
<thead>
<tr>
<th>Serial Number:</th>
<th>Date of Surgery:</th>
</tr>
</thead>
</table>

Did the product have any Patient Contact?  
- Yes  
- No

Was the lens itself:  
- Destroyed  
- Discarded  
- Lost  
- N/A

If yes, please state: ___________________________________________________________

Was this an issue due to:  
- Handling/User Error? (NO product complaint)  
- Defective Product?  
- Other*

Specifically (check any/all that apply):  
- Loading Issues  
- Debris on Lens  
- Folding / Unfolding Issues
- Cartridge Defective  
- Stuck in Delivery System  
- Broken Haptic  
- Other (note below)  
- Cracked / Torn Lens

Cartridge Lot #: ________________________

Was the IOL explanted/removed from the eye?  
- Yes  
- No

If yes, Date of implant ________________  
  Date of Explant ____________________

Was the incision enlarged to remove IOL?  
- Yes  
- No

Was there any patient injury?  
- Yes  
- No

Was another lens used? ________________________  
  *If yes, same model? ________________________

*Notes / Other:

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**LENSTEC STAFF USE ONLY**

Awareness Date: ________________________

Return Authorization Number Assigned: ________________________  
  By/Date: ________________________

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