LENSTEC, INC.
1765 Commerce Avenue North, St Petersburg, Florida 33716
Tel: 1 (866) 536-7832 Fax: 1 (866) 536-3040

CUSTOMER RETURN AUTHORIZATION FORM

Contact Person:				Date:	
CUSTOMER DETAILS					
Company Name:					
Address1:					
Address2:					
City:		State:		Zip Code:	
Telephone No:			Fax No:		

Device Serial No.	Patient Contact (Y/N)*	Model/Device	Injector (Cartridge) Type & Batch#	Doctor	Reason for Return

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

	Total Returns

SHIPPING DETAILS

Date Shipped	Shipped Via (CARRIER)	No. Cartons		Total Weight (in lbs)	AWB NUMBER

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.**

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

Serial Number: _____ **Date of Surgery:** _____

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? (if yes, please explain) ☐ Yes ☐ No

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

***Notes / Other:**

LENSTEC STAFF USE ONLY

Awareness Date: _____

Return Authorization Number Assigned:_____ **By/Date:**_____

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