Post Trial Summary Evaluation Form: Part A

Thank you for your feedback. Please complete one form for each trial.
Send completed forms to trial.requests@bipadsurgical.com

DATE:

Lead Surgeon / Clinician Name (Initial Requester):	**Title: MD, DO, RN, NP, PA**
Email Address:	**Office Phone:**
Facility Name:	**Mobile Number:**
Sales Rep Name:	**Sales Rep ID:**

Trial Information

Overall was the result of the trial successful? ☐ **YES** ☐ **NO**

If yes, please comment:
If no, please explain:

When will you need more product? ☐ **1—4 weeks** ☐ **2—3 months** ☐ **Greater than 3 months**

Estimated Monthly Quantity: ☐ **less than 80** ☐ **Case of 80** ☐ **More than 80**

Is there anything you would like to see in the future versions of the product?

O.R. Contact Name:	**Title:**
Hospital Name:	**Phone Number:**
Fax Number:	**Email Address:**

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