Quick Tube Medical Quick Tube Medical, LLC

Attn: Michael Augustine

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**Quick Tube Chest Tube Training Certification Form**

This certification form confirms that the undersigned healthcare professional has completed the required training for the safe and effective use of the Quick Tube Chest Tube, a medical device designed to treat pneumothorax, manufactured by Quick Tube Medical, LLC.

Physician Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Medical License Number: \_\_\_\_\_\_\_\_\_\_\_\_

Institution/Hospital: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Training Completion: \_\_\_\_\_\_\_\_\_\_\_

Training Requirements Completed: By signing below, I certify that I have:

1. Read and understood the Instructions for Use (IFU) for the Quick Tube Chest Tube, available on the Quick Tube Medical website. quicktubemedical.com
2. Watched all instructional videos demonstrating the proper deployment and use of the Quick Tube Chest Tube, as provided on the Quick Tube Medical website.
3. Understood the unique placement technique for the Quick Tube Chest Tube, which differs from traditional chest tube placement methods.

I acknowledge that I am responsible for applying the training and IFU guidelines correctly during the placement and use of the Quick Tube Chest Tube. I confirm that I have the necessary skills, knowledge, and clinical judgment to use the device safely and effectively in accordance with its intended purpose.

Indemnification: I agree that Quick Tube Medical shall not be held liable for any adverse outcomes, complications, or damages arising from my use or misuse of the Quick Tube Chest Tube, including but not limited to improper placement, failure to follow the IFU, or deviations from the training provided. I hereby indemnify and hold harmless Quick Tube Medical, its officers, employees, and affiliates from any claims, liabilities, or legal actions resulting from my actions or omissions during the use of the Quick Tube Chest Tube, provided that such use is not due to a defect in the device itself as determined by applicable regulatory standards.

Physician Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s Date\_\_\_\_\_\_\_\_\_\_\_\_\_

Note: This certification does not replace any institutional or regulatory requirements for credentialing or privileging to perform chest tube placement procedures.