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| **PRODUCT DISTRIBUTION (SHIP) REQUEST FORM** |

***Requestor to complete the section below and submit to Customer Service for approval***

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| --- | --- | --- |
| **REQUEST INFORMATION** |  | **RECIPIENT SHIPPING INFORMATION** |
| Requested By/Date:  {{loggedin\_user}}  {{date\_requested}} |  | Contact Name: {{recipient\_name}} |
|  | Hospital/Facility Name: {{site\_name}} |
| Date Needed: {{needed\_by\_date}} |  | Street Address: {{address}} |
|  |
| Protocol #: 2053 |  |
| Complaint Replacement: {{complaint\_request}}  *(if yes, include Incident# in Special Instructions)* |  | City, State, Zip Code: {{city}}, {{state}}, {{zip}} |
|  | Country: {{country}} |
|  | Phone Number: {{phone}} |
| Order #: |  | Email Address: {{email}} |
| Request #: *R{{sequence\_number}}* |  |  |
|  |

***Requested Product***

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **QTY** | **PART/REF NUMBER** | **DESCRIPTION** | **LOT or SERIAL NUMBERS**  (Completed by Shipping) | |
| {{patch\_kit\_qty}} | 900-00031 | Patch Kit |  | |
| {{mdu\_qty}} | 900-00032 | ES-2 Defibrillator Unit MDU |  | |
| {{starter\_kit\_qty}} | 900-00036 | ES-2 Starter Kit |  | |
| {{skin\_prep\_kit\_qty}} | 820-00601 | Skin Prep Kit |  | |
| {{removal\_kit\_qty}} | 820-00600 | Removal Kit |  | |
| {{placement\_accessory\_qty}} | 900-00033 | Placement Accessory |  | |
| {{ht\_qty}} | 445-00014 | Hair Trimmer |  | |
| {{ifu\_qty}} | 320-00027 | Jewel Patient Guide, ES-2 Device |  | |
| {{adhesive\_laminate\_qty}} | 820-00280 | Adhesive Laminate |  | |
| {{mdu\_return\_qty}} | N/A | MDU return material |  | |
| {{patch\_return\_qty}} | N/A | Patch-Kit return material |  | |
| {{ placement\_accessory\_return\_qty}} | N/A | Placement Accessory return material |  | |
| {{return\_label\_qty}} | N/A | Return Labels (x6) |  | |
| **Special Instructions:** {{special\_instructions}} | | | | |
|  | | | | |
| **SHIP FROM:  Element Science, Inc.  Distribution Center: \_\_\_\_\_\_\_**  **CSM: \_\_\_\_\_\_  Other (see below)** | | | | **SHIPPING METHOD USED** (filled out by shipping)  **FedEx  UPS  USPS  Hand Carry** |
| Contact Name: | | | | **First AM (8 AM)** |
| Hospital/Facility Name | | | | **Priority Overnight (10 AM)** |
| Street Address: | | | | **Standard Overnight** |
| City, State, Zip Code: | | | | **2 Day** |
| Country: | | | | **3 Day** |
| Phone Number: | | | | **Ground** |
| Email Address: | | | | **Freight** |
| **SPECIAL INSTRUCTIONS:  N/A** | | | | |
|  | | | | |

***Clinical Sign-off***

|  |  |  |
| --- | --- | --- |
| **Name:** | **Sign:** | **DATE:** |

***Customer Service Sign-off***

|  |  |  |
| --- | --- | --- |
| **Name:** | **Sign:** | **DATE:** |

***Shipping to complete***

|  |  |
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| **Transaction Number(s):  N/A** |  |
| **Tracking Number(s):** |  |
| **Comments:  N/A** | |

***Shipping Sign-off***

|  |  |  |
| --- | --- | --- |
| **Name:** | **Sign:** | **DATE:** |

***Inventory updated in Netsuite***

|  |  |  |
| --- | --- | --- |
| **Name:** | **Sign:** | **DATE:** |