|  |  |  |
| --- | --- | --- |
| **SCAR #:** |  | |
| **SECTION 1**  *GT Medical complete this section. (N/A sections that are not applicable)* | | | | | | | | |
| Supplier Name: | | Critical  Non-critical | | | Address: | | | |
| Contact Name: | | | | |
| Phone Number: | Fax Number: | | | |
| Email: | | | | |
| **Nonconformance** | | | | | | | | |
| Product/Part Name: | | | | | | | | |
| P/N: | | Lot Number(s): | | UDI(s), if applicable: | | | | Quantity(ies): |
| Description of nonconformance: | | | | | | | | |
| Determination of adverse trend: Based on review of SCAR log and/or Supplier Quality Performance Review, does nonconformance represent an adverse trend? See SOP-002 section ‘Settlement of Quality Disputes and Supplier Corrective Action’.  Yes  No | | | | | | | | |
| Approved By *(Print Name and Title)*: | | | Signature & Date: | | | | | |

|  |  |
| --- | --- |
| **SECTION 2**  ***Supplier:*** *Complete this section.* | |
| **Containment** | |
|  | |
| **Root Cause** | |
|  | |
| **Corrective Action** | |
|  | |
| **Preventive Action** | |
|  | |
| **How corrective action will be verified? Evidence/Rationale that supplied product will not be adversely affected?** | |
|  | |
| Completed By *(Supplier Print Name and Title)*: | Supplier Signature & Date: |

**\*\* Return completed signed SCAR to GT Medical (via email as *.pdf* attachment) \*\***

|  |  |  |
| --- | --- | --- |
| **SECTION 3**  *Internal Use only.* ***Supplier:*** *Do not complete this section.* | | |
| **Additional Follow-up Required?** | | |
| ☐Yes  ☐No | If Yes, Performed By *(Print Name and Title)*: | Signature & Date: |
| **CLOSURE** | | |
| Closed By *(Print Name and Title)*: | | Signature & Date: |

*This form may be input electronically for legibility purposes. Electronic input may result in multiple pages.*