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Feedback Form

Information to this form

Dear customer,

to be able to process your feedback as quickly as possible, we kindly ask you to use this form for your problem report. It will help you to collect all relevant data and information concerning an event, in order to make a safe report. These information also help us to find possible causes as soon as possible and implement remedial measures. To make your work easier, we have integrated a feature that sends your form automatically via E-mail. Alternatively, you can print the form and mail it to us or include it in your return shipment.

If you have suggestions for improvement or questions, we are happy to receive an E-mail from you. md-vigilance@corpuls.com

1.) Sales partner information

Company name		**GS customer number**	
Street / No.		**Contact person**	
Zip code		**Phone**	
City		**E-Mail**	
Country			

2.) Information concerning the defective device/product

Product		**Article name Accessory**	
Product number		**GS Delivery sheet-No.**	
Serial number		**SW version**	
		FW version	
		Charge	
		Assesment Priority	Low

Error description	
Where is the defective device now?	
First device analysis by service partner	
Repair History	

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3.) Information about User

Company name		**Contact person**	
Street		**Phone**	
ZIP code		**E-Mail**	
City		**Internal Mission No.**	
Country			

4.) Information concerning the mission

Time of error occurrence

Date **Time** **corpuls Mission No.**

Error Repeatable

Environmental conditions **General** **Temperature**

Further electr. devices at the emergency site

Patient information skin ◯ dry ◯ moist ◯ hairy ◯ oily **Temperature**

Where did the error occur? (e.g. rescue vehicle, bed, floor)

Used consumables still available? ☐ Yes ☐ No

Used consumables/ supplies*

Behaviour of user after error occurrence

* If possible, the used accessories/consumables should be sent to GS for further error analysis.
If possible, attach mission data as zip-archive.

Mission data attached ☐ **Yes** ☐ **No**

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5.) Information concerning regulatory authority

Authority report	☐ No	☐ Yes	**Authority name**	
			Procedure No.	
Known injury to patient	☐ No	☐ Yes	**Description Patient injury**	

6.) Further information

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