

Note: Please keep the Investigational Product Sticker of any device opened/used. If more than 2 devices were used, please complete another form if using as source.

CLAAS Device Size	<input type="checkbox"/> Regular (27 MM) <input type="checkbox"/> Large (35 MM)	CLAAS Device Size	<input type="checkbox"/> Regular (27 MM) <input type="checkbox"/> Large (35 MM)
Lot #	Place product sticker here	Lot #	Place product sticker here
Device Outcome	<input type="checkbox"/> Used <input type="checkbox"/> Opened, Not Used <input type="checkbox"/> Opened, Used, Disposed <input type="checkbox"/> Opened, Used, Returned <input type="checkbox"/> Opened, Not Used, Returned	Device Outcome	<input type="checkbox"/> Used <input type="checkbox"/> Opened, Not Used <input type="checkbox"/> Opened, Used, Disposed <input type="checkbox"/> Opened, Used, Returned <input type="checkbox"/> Opened, Not Used, Returned
Did device meet position criteria?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Did device meet position criteria?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Did device meet anchor criteria?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Did device meet anchor criteria?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Did device meet seal criteria?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Did device meet seal criteria?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Was partial resheath attempted?	<input type="checkbox"/> Yes, number of partial attempts: _____ <input type="checkbox"/> No	Was partial resheath attempted?	<input type="checkbox"/> Yes, number of partial attempts: _____ <input type="checkbox"/> No
Was a full resheath attempted?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Was a full resheath attempted?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Did device deficiency or device malfunction occur?	<input type="checkbox"/> Yes <i>If yes, complete a Device Deficiency Form</i> <input type="checkbox"/> No	Did device deficiency or device malfunction occur?	<input type="checkbox"/> Yes <i>If yes, complete a Device Deficiency Form</i> <input type="checkbox"/> No

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Site Personnel Signature

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Date (DD/MMM/YYYY)