## Return Authorization Request Form



500.300.F01

Requestor	Company:	
MiMedx Employee:		
<b>RETURN AUTHORIZATION REQUEST</b>		
Facility Name:		
Facility Address:		
Requestor Email Address:		Phone:
Detailed Reason for Return:		
Product Number & Description	Tissue Identificat	ion Numbers
Customer Signature:	D	ate:
Authorized Representativ		
Printed Name & Title:		
For MiMedx Group Use Only		
		Davisian Number
Page: Page 1 of 1	Effective Date: 08/10/2020	Revision Number: 4

The documentation and information contained in this procedure are confidential. They are the property of MiMedx Tissue Services, LLC and are not to be copied, distributed, or forwarded to third parties without written permission.