

**Return Authorization
Request Form
F500-0300-001**



Requestor:
Company:
MiMedx Employee:

RETURN AUTHORIZATION REQUEST

Facility Name:	
Facility Address:	
Requestor Email Address:	
Phone:	
Detailed Reason for Return:	
Product Number & Description	Tissue Identification Numbers

***By signing below, I confirm that the above product(s) was maintained at the required storage conditions during the entire time in my possession and was not exposed to conditions or potential contamination that may affect its quality or integrity of the package or the product. I have read and understand MIMEDX Group Inc's Return policy.
<https://www.mimedx.com/returns-policy/>***

Customer Signature:

Date:

Printed Name:

For MiMedx Group Use Only

Page:

Effective Date:

Revision Number:

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Awaiting Training

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