Vyaire® Medical Warranty Claim Form

(1) Dealer Reference P.O. Number*:

(2) Customer Details	Business Partner	Hospital/Customer
Organization Name*		
Name (reporting person)*		
Email Address*		
Title*		
Telephone*		
City*		
Province*		
Country*		

(3) Equipment and problem details:	
Manufacturer*	
Product description*	
Product Serial number / LOT number*	
Installation date*	
Installation record submitted?*	
Date of Occurrence* (day/month/year)	
Software Version*	
Detailed Description of Fault* • Full error code / continuous / intermittent • Software options / Networked / Configuration • Alarm Details • Running Hours • Reproducible? • Video, Bike, Body Box Settings • Was this unit on a patient at the time of the Occurrence? • If on a patient, what is the patient's status? (Injured, Death, on replacement ventilator?) • Ventilator settings, mode	

(4) Troubleshooting steps/Result:
(5) Calibration data:

(6) Part Claimed Under Warranty:			
	Item 1	Item 2 (If necessary)	Item 3 (If necessary)
Spare part description*			
Part number*			
Defective part LOT number*			
Defective part serial number*			
Replacement part serial number*			
Claim quantity*			
Replacement Parts Ship To address:*			

For any questions, please contact Technical Support.
Support.Vent.US@CareFusion.com
Support.VMax.US@CareFusion.com
Support.SMCVent.US@CareFusion.com
Support.Sleep.US@CareFusion.com
Support.Jaeger.US@Carefusion.com

* Mandatory Field