Warranty Claim Form for Vendors

Please make sure that all the fields are filled out and that the patient can be contacted later by Medistrom Technical Support to confirm and troubleshoot the problem they are experiencing with the Backup Power Supply.

TODAY's DATE: _____

VENDOR INFORMATION
Vendor:
Contact Name:
Contact Phone Number:

PATIENT INFORMATION	
Patient's First Name:	**Patient's Last Name:**
Patient's Phone Number:	

Please provide a valid patient phone number. If the patient cannot be contacted there may be a delay in issuing your RMA.

BACKUP POWER SUPPLY INFORMATION	
Medistrom Backup Power Supply Unit:	
14 Digit Serial Number (S/N):	
Date of Purchase:	
The last charge date of the Medistrom Backup Power Supply when it was being stored (either by vendor or patient):	
Make of PAP Machine used with Backup Power Supply:	
Model of PAP Machine used with Backup Power Supply:	
Date when problem was first experienced:	
Was the Backup Power Supply being used in Backup or Battery Configuration when issue occurred:	
Pressure Setting:	**Humidifier Setting:**
Heated Hose Setting:	
Issue Description including Error Codes and Other Notes:	

Choice One Medical
O: 1-888-407-4791 | F: 647-846-1263
info@choiceonemedical.com
57 Atomic Avenue, Toronto, ON, M8Z 5K8
www.choiceonemedical.com / www.medistrom.com