AFFIRMATIVE SOLUTIONS
"Making a difference in the world"

Usage Confirmation Form

(Request for Purchase Order)

SDVOSB Medical Device Distributor
Cage#: 54J23 / UE ID#: DNV7E1GBTDW7 / FSS: 36F79722D0022 / SAC: 36C10G18D0127
ECAT: SPE2DE-21-D-7011 "JIT" / DAPA: SP0200-11-H-0052

Special Instructions (SI) Codes

Pending= **P** Bill Only = **BO**
Distributor Consignment= **DC**
Office Consignment= **OC**
Hospital Consignment= **HC**
Special Shipping= **SS**

Hospital Name _____ Hospital Account # _____

Surgeon _____ Surgery #_____ **Date** _____

Patient Name & last 4 SS# _____ Tracking/Q # (if applicable) _____

PLEASE FAX AFFIRMATIVE SOLUTIONS FOR PRESURGERY & POST SURGERY CONTRACTING @ 1-877-879-7811 OR 404-601-9885
If you have any question call 866-994-7986 or e-mail: info@affirmativesolutions.org

Item	Qty	Lot #/Tissue ID	Item Description	SI	Unit Price	Total Price
101-CMC-141			Ensemble CMC Interpositional Implant, Sz 141 Thumb: ☐ L or ☐ R	ea.	$ -	$ -
101-CMC-151			Ensemble CMC Interpositional Implant, Sz 151 Thumb: ☐ L or ☐ R	ea.	$ -	$ -
101-CMC-161			Ensemble CMC Interpositional Implant, Sz 161 Thumb: ☐ L or ☐ R	ea.	$ -	$ -
					$ -	$ -
					$ -	$ -
					$ -	$ -
					$ -	$ -
					$ -	$ -
					$ -	$ -
					$ -	$ -
					Sub Total	$ -

Comments / Special Shipping Instructions:

Credit Card #	Name on Credit Card	Security Code	Expiration Date

Cardholder's Email Address	Cardholder's Phone Number	Phone Ext.

Sales Rep (include cell & fax numbers)	Hospital Personnel's Signature (authorization)	Date

By sigining above, I am certifying that these are the correct items and quantities used in this surgery.

Pending #	PO #

Please see package insert for the complete list of indications, warnings, precautions and other important medical information