ACH Medical

Failed Implant Return Form

Reporting Date	/ / (MM/DD/YYYY)
Name of Dentist / Clinic	
Clinic Address	City : State : Zipcode :
Patient Information (Name/Age/Gender)	Name : Age : Male / Female
Product Information	REF No : Lot No. :
Fixture Placement Date	/ / (MM/DD/YYYY)
Failure Date	/ / (MM/DD/YYYY)
Fixture Label	Attach the Fixture Label Here

Attach the failed implant in a transparent sealed bag here

Do not clean the failed implant.

Send it to ACH Medical as it is for our internal reference to improve the product

Please note, to qualify for a failed implant replacement, ACH Medical needs the following documentation and information :

1. This form must be filled in by the dentist/clinic manager.
2. Contact your local distributor and arrange with the consultant to collect the failed implant.
3. Submit one copy of the return form per failed implant.