



Service Request Form

Date: _____ OPTIM Return Authorization Number: _____

Facility Name:	_____		
Contact Name & Title:	_____		
Shipping Address:	_____		
City:	State:	Zip:	
_____	_____	_____	
Telephone #:	Fax #:	_____	
_____	_____	_____	
Email:	Mobile #:	_____	
_____	_____	_____	
Model:	Serial Number:	_____	
_____	_____	_____	
Reason for Return:	_____		

OPTIM requires written authorization before proceeding with all repairs. A minimum \$100.00 fee applies to all non-warranty evaluations/repairs. Fee is waived with repair/replacement approval.

- **ALL MEDICAL INSTRUMENTS MUST BE PROPERLY DISINFECTED PRIOR TO RETURN**
- Please properly package the product requiring service for shipment, following user manual guidelines and include your completed version of this form.
- Please See That This Shipping Label Is Cut Out & Placed On The Outside Of Your Package. Your Package May Be Rejected & Returned Back To You.

OPTIM LLC
RMA # _____
64 Technology Park Road
Sturbridge, MA 01566

F9-6 DCN's A-02100, B-04600, C-06000, D-07802, E-02404, F-02808, G-05410



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