

Dentist's Name..... GDC No..... Date Sent..... Date Required.....

Address..... Practice No.....

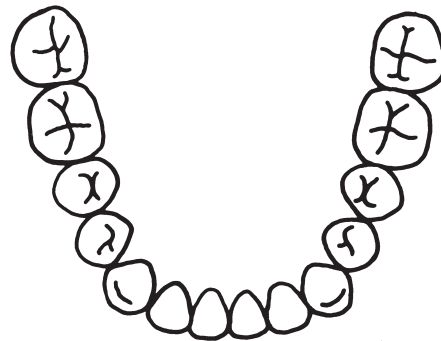
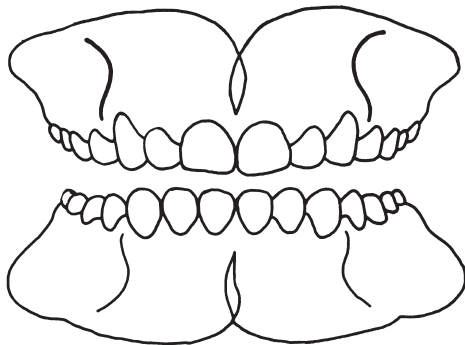
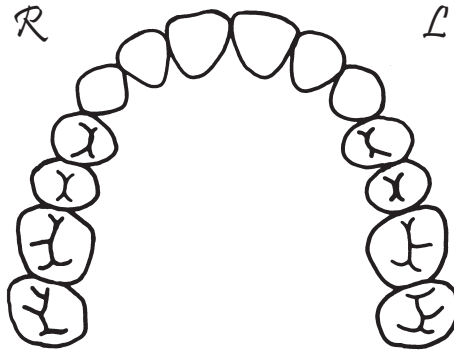
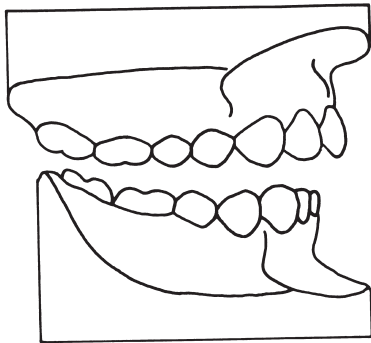
Custom-made device for the exclusive use of.....

Patient's D.O.B..... M/F..... Patient's Ref.No.....

IMP. DISINFECTED BITE SENT FUNCTIONAL REMOVABLE FIXED STUDY MODELS

APPLIANCE REQUIREMENTS

CUSTOM PLATE DESIGN: UPPER A..... UPPER B.....
 LOWER A..... LOWER B.....



PATIENT STATEMENT

This is a custom-made medical device that has been manufactured to satisfy the design characteristics and properties specified by the prescriber for the above named patient. This medical device is intended for exclusive use by this patient and conforms to the relevant essential requirements specified in Annex 1 of the Medical Devices Directive and the United Kingdom Medical Devices Regulations. This statement does not apply to medical devices that have been repaired and/or refurbished for an individual patient's use.

THIS APPLIANCE IS SUPPLIED IN A NON-STERILE STATE

| | |
|--------------------------------|---------|
| Office use only | |
| reviewed and accepted by | |
| date | |
| signed | |
| Prescription alteration | |
| | |
| date | |
| signed | |
| | made by |
| imp. cast | |
| wire work | |
| acrylic/pol. | |
| Final check made | |
| Signed | |