



Repair Modify
 Return for Credit

Date: _____

Patient: _____

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Last Name

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First Name, M.I.

Date of Birth (MM/DD/YYYY)

Serial Number _____

(Processor, transfer unit and connector wire must be returned as a set.)

NOTE: Removal of the pull tab invalidates any warranty, implied or otherwise, on the connector wire assembly.

Repair/Modify In Warranty Out of Warranty

In order for a repair or modification to be processed, the following information must be completed:

- | | | |
|--|--|---|
| Performance | Mechanical | Shell |
| <input type="checkbox"/> Dead (R1) | <input type="checkbox"/> Volume Control (R7) | <input type="checkbox"/> Too Loose (M1) |
| <input type="checkbox"/> Weak (R2) | <input type="checkbox"/> Wire Connector (R8) | <input type="checkbox"/> Too Tight (M3) |
| <input type="checkbox"/> Intermittent (R3) | <input type="checkbox"/> BTE Case (R9) | <input type="checkbox"/> Canal Too Short (M2) |
| <input type="checkbox"/> Noisy/Static (R4) | <input type="checkbox"/> Button (R10) | <input type="checkbox"/> Canal Too Long (M4) |
| <input type="checkbox"/> Distortion (R5) | <input type="checkbox"/> Battery Door (R11) | |
| <input type="checkbox"/> Feedback (R6) | | |

Other (specify): _____

Have you made shell modifications? Yes No

Signature of Hearing Healthcare Professional

This section for lab use only

	<small>TRANSFER UNIT</small>	<small>PROCESSOR</small>	<small>CONNECTOR WIRE SIZE</small>
In	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Out			
HFSN:			
Evaluation Data			

Ship To

Account No. _____

Contact for this order: _____

PURCHASE ORDER NUMBER (if applicable): _____

Business Name: _____

Street: _____

City: _____ State/Province: _____

Zip/Postal Code: _____ Country: _____

Phone: (____) _____ Fax: (____) _____

e-mail: _____

Bill To (if different from 'Ship To' Address & Account No.)

Account No. _____

Business Name: _____

Street or P.O. Box: _____

City: _____ State/Province: _____

Zip/Postal Code: _____ Country: _____

Return for Credit Date of Original Order _____

Refer to "TransEar Prices & Policies" for RFC policies.
 In order for an RFC to be processed and a credit applied to the account, the following information must be completed:

Comfort/Fit
Were modifications made to the shell? Yes No

Performance/Sound Quality
Were Sound Field Tests performed? Pre-Fit Post-Fit

Medical
Please specify: _____

Other
Please specify: _____

Signature of Hearing Healthcare Professional

Ear Technology Corporation (ETC) provides pre-printed labels for the purpose of shipping instruments to our facility. For repairs and/or remakes during the warranty period, ETC assumes the cost of standard shipping, both inbound and outbound. Expedited shipping services are subject to additional charges. For shipment of instruments outside the warranty period, shipping charges, both inbound and outbound, are billed at actual cost. Refer to Prices & Policies for complete terms.

EAR TECHNOLOGY CORPORATION

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