CURITEVA®

Surgery Date: ____________________
PO Number: ____________________
☐ Re-faxed for PO only

Generic Surgical Case Form

Surgery Information	
Customer Name:	
Customer ID:	
Surgeon Name:	
Patient ID:	
Levels:	

Representative Information	
Name:	
Distributorship:	
Contact #:	

Tray / Caddy # (REQUIRED)	

Part #	Description	Lot #	Qty Used	Unit Price	Extended Price
				TOTAL:	

Please email completed sheet to customersupport@curiteva.com or fax to (256) 213-1058

Hospital Representative

Authorized Signature   Printed Name   Title

Representative

Authorized Signature   Printed Name

☐ Ship To / Restock Information	
First & Last Name	Required Date & Time
Address	
City, State, Zip	
Additional Instructions	