

Post Market Surveillance (PMS) Clinical Use Survey



Thank you for taking the time to complete our short survey.
Your feedback is important to us and will be used to further improve our products and services.

End User Name	Product Code
Title/Rank/Profession	Product Description
Organisation Name	
Contact Number	Date of Supply
Email address	

Please tick

1. Have you noticed any deterioration of fitness for purpose with repeated use of the device? YES ☐ NO ☐

If YES please explain

2. Does the design of the device continue to satisfy your current state of the art requirements for the procedure(s) or purpose for which it is intended? YES ☐ NO ☐

If NO please explain

3. Did you undertake any clinical monitoring or other follow-up that could be used to assist Post-Market Surveillance for this device? YES ☐ NO ☐

4. If yes to the above are you prepared to share this information? YES ☐ NO ☐

If YES please give further details

5. Do you have any further comments? YES ☐ NO ☐