GPS Evaluation Request Form

Evaluation Dates_____ Distributor_____
Rep_____ Phone_____ Email_____
Hospital_____ City, State_____
Surgeon(s) & Approach
1._____ 2._____ 3._____

1. Type of Software: ___ Anterior ___ Posterior ___ Both
2. Product of interest: ____ Tower ____ Tablet ____ Both
3. Approval from OR Supervisor? ____ Yes ____ No
4. Has Radiology been notified of the evaluation? ____ Yes ____ No
5. Make and Model of C-Arm? _____
6. Does the hospital require a Product Evaluation Form? ___ Yes ____ No
7. Is a hospital purchase order required to start the evaluation? ____ Yes ____ No
8. Does the facility have capital budget available for a 2016 PO? ___Yes ___No
9. Is the hospital tax exempt? ____ Yes ____ No
10. Does the surgeon(s) currently use digital x-ray intra-operatively? __ Yes __ No
11. How many procedures are being done per month? _____
12. Does the surgeon use DePuy implants? _____ Yes _____ No.

    If not, what company does the surgeon use? _____

Key Hospital Contacts

OR Director: _____
Contact Number _____ Email_____
Purchasing Director: _____
Contact Number _____ Email_____
Radiology Director: _____
Contact Number _____ Email_____
Hospital IT Contact: _____
Contact Number _____ Email_____
Radlink Operator(s): *hospital appointed*
1._____ 2._____ 3._____