Reset Form

MEDICAP® HOME MEDICAL

Product Recall Form

Person Completing Form: _____ Date: _____

Product: _____

Name of Vendor/Manufacturer: _____

Phone #: _____ Email: _____

Contact Person: _____

Notified of Recall Via: _____ Date: _____

Description: _____

Model # & Lot # Involved: _____

Recall Initiated by (Check one): Manufacturer ☐ Supplier ☐ Hospital ☐

Returning to Stock? Yes ☐ (Qty Returned _____) No ☐

Date	Lot Number	Location of Product	Action Taken

Other Comments/Actions Taken

Reserved for QA Committee:

Reviewed: _____ Date: _____ Control Number: _____