**Medical Device Reprocessing Interference Incident Intake Form**

**Instructions**  
• Complete electronically or print and scan; expand text boxes as needed.  
• Attach all relevant e-mails, screenshots, contracts, or other evidence.  
• Submit the completed form and attachments to **info@amdr.org**.

**1 Reporting Facility & Contact (*required*)**

|  |  |
| --- | --- |
| Facility Name |  |
| Location (City, State) |  |
| Your Name |  |
| Your Email |  |
| Your Phone |  |
| Date of Incident |  |

**2 Device Category & Reprocessing Context (*required*)**

| **Device category – check all that apply** |  |
| --- | --- |
| Electrophysiology (Cardiac Mapping) |  |
| Surgery |  |
| Patient Floor |  |
| Office Based Lab / Ambulatory Surgical Center |  |
| Other (Describe): | |

**Reprocessing partner(s)** (company providing third-party reprocessing):

**3 Device Information (*required*)**

|  |  |
| --- | --- |
| Original Equipment Manufacturer (OEM) |  |
| OEM representative(s) involved (Name) |  |
| Device Name |  |
| Reprocessor | |  |

**4 Nature of Interference** (*check all that apply and complete correspondent sub-sections*)

|  |  |
| --- | --- |
| **A. Clinical Support** | Support withheld or downgraded because reprocessed devices were in use. |
| **B. Blocking Technology** | Reprocessed device rejected or disabled by system update or “smart chip.” |
| **C. Collection Practices** | OEM or agent removes used devices, preventing you from sending them to reprocessor. |
| **D. Other OEM Interference (Describe)** |  |

Signature (e.g. /Your Name/):

Date (MM/DD/YYYY):

*Electronic Signature Consent*

*By typing your name between two forward slashes on the line above (e.g., /Your Name/), you consent to transact electronically and agree that this action constitutes your electronic signature.*

***Thank you*** *for helping AMDR protect hospital access to FDA-regulated reprocessed medical devices.*