



PERFORMANCE PROGRAM

Performance Evaluation Form

Today's Date _____

Prescribing Physician Information

Prescribing Physician Name _____

Physician Address _____

Postal Code _____

Province / Region _____

City _____

Country _____

Patient Information

Patient Name _____

Fracture Diagnosis _____

Date of EXOGEN Prescription _____

EXOGEN Serial Number _____

(back of device)

Additional Information



I confirm that I have been treating the above patient for a fracture site which showed no visibly progressive signs of healing (progression to bony union) after at least 120 days of continuous EXOGEN treatment. I have made the evaluation based on X-Rays taken prior and after the patient's treatment with EXOGEN.

Must be signed by prescribing physician

Print _____

Signature _____ Date _____

Please print and sign document

Please complete, sign and return this form to:

Bioventus Coöperatief U.A.
Taurusavenue 31
2132 LS Hoofddorp
The Netherlands

www.BioventusGlobal.com
www.exogen.com

Distributed by: [Empty box]

