

Today's Date: _____

Prescribing Physician Information	
Prescribing Physician's Name	
Hospital Name	

Patient Information	
Patient Initials	
Fracture Diagnosis	
Treatment Start Date	
Date of Final Evaluation	
EXOGEN Serial Number (back of device)	
Additional Information	
<input type="checkbox"/> I confirm that I have been treating the above patient for a bone fracture which showed no visibly progressive signs of healing (progression to bony union) after at least 120 days of consecutive EXOGEN treatment. I have made the evaluation based on X-rays taken prior to and after the patient's treatment with EXOGEN.	



Must be signed by prescribing physician

Print: _____

Signature: _____ Date: _____

Please complete, sign, and return this form to:

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

Customer Care
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E: CustomerCare-International@BioventusGlobal.com