**MEDICAL DEVICE EVALUATION FORM**

Description of Device:

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Method(s) used to evaluate the device:

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Summary of Results of the Evaluations:

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Reasons Device is selected or rejected for use:

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Administrator Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Director of Nursing Date

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Facility