

Return Authorization  
Request Form



500.300.F01

Requestor \_\_\_\_\_ Company: \_\_\_\_\_

**RETURN AUTHORIZATION REQUEST**

Facility Name:	
Facility Address:	
Reason for Return:	
Product Number & Description	Tissue Identification Numbers

Customer Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Authorized Representative

Printed Name & Title: \_\_\_\_\_

***For MiMedx Group Use Only***

<b>Return/Transfer</b>		
<b>Approved By:</b> <i>(N/A if Consignment)</i>	<b>Date:</b>	
<i>Approval must be granted by President/COO, EVP of Global Sales, or VP of Sales Operations</i>		
<b>RMA# Issued:</b>	<b>By:</b>	<b>Date:</b>