



Department of Veterans Affairs
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Job #

Repair Facility

For Internal Use Only

EVALUATION REQUEST FORM

Facility Information

Station Number:					
Medical Center:					
Shipping Address:					
City:		State:		Zip Code:	

Point Of Contact

Name:				
Phone Number:		PO#		
E-mail Address:				

Equipment Information

Manufacturer:			
Model:		Serial Number:	

Description Of Problem:

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Equipment Has Been:

Sterilized

Disinfected

Method of Sterilization:	
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