

Surgeon's Name..... Job No ..... Date Sent ..... Date Required .....

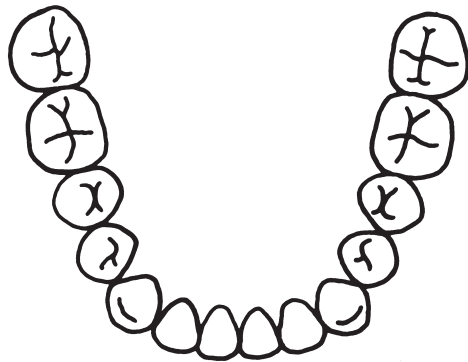
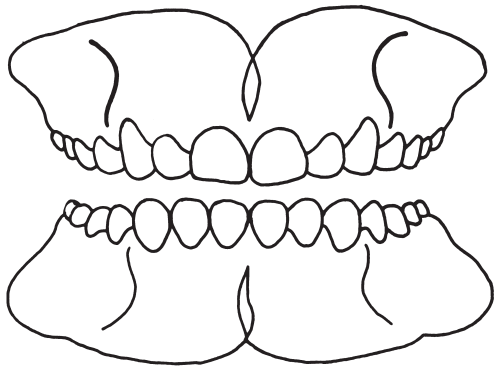
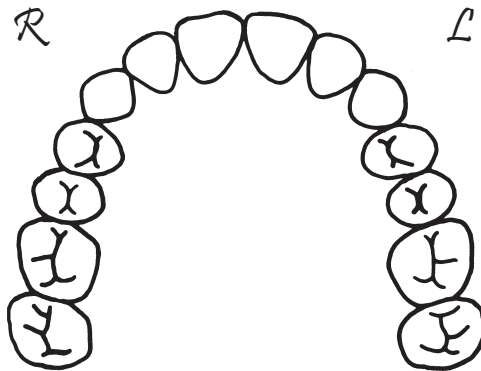
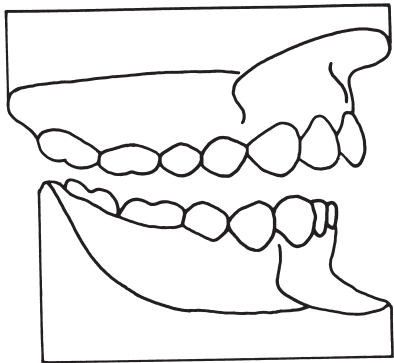
Address .....

Custom-made device for the exclusive use of .....

IMP. DISINFECTED  BITE SENT  FUNCTIONAL  REMOVABLE  FIXED  STUDY MODELS

### APPLIANCE REQUIREMENTS

CUSTOM PLATE DESIGN: A..... B.....



<b>Office use only</b>	
reviewed and accepted by .....	
date .....	
signed .....	
Prescription alteration	
.....	
date .....	
signed .....	
	made by
imp. cast	
wire work	
acrylic/pol.	
Final check made	
Signed .....	

### STATEMENT

When final check is signed by the Dental Laboratory this device conforms to the relevant essential requirements set in Annex I of the Medical Directive (93/42/EEC)

**THIS APPLIANCE IS SUPPLIED IN A NON-STERILE STATE**