## **CERTIFICATION FOR RETURNED PRODUCTS**

Beginning of Form

OSPITAL NAME:		ABO & Rh	ImpactLife Use Only Reissuing Evaluation Acceptable Upon Return	
<b>Unit Number</b>	<b>Product Code</b>		Yes	No*
			165	110
f unacceptable notify hospital: Tech:	Date/Time:	@	Caller:	
quirements for Return of Products:  1. The blood component container has a 2. An original segment is properly attacl required for return to the blood center 3. Products have been stored continuous	ned and has not been rem	noved. A minimum	of two (2) segn	nents are
ERTIFICATION: THE ABOVE CO ETURNED FOR REISSUE.	NDITIONS HAVE	BEEN MET AN	D THE UNI	T(S)
spected and Packed By:	Date: _	Tim		ILITARY TI
	ImpactLife Use Only	<b>v -</b>	M	LHAKI II
Received By:				
•				
Date:	Time	e:		

End of Form

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