

Appendix 1: Certificate of Medical Necessity (CMN) Form

Please provide the following information:

Customer name:
Address:
City: State:
Zip/Postal Code: Country:
After reading the attached Notification Guide regarding the FDA findings at the Atrium Hudson manufacturing facility, I certify that I evaluated the relevant risks and benefits and concluded that there is an immediate medical need for the continued use and purchase of the Atrium products checked below and their associated parts, components, and accessories.
 □ Chest Drains (Ocean/Oasis/Express) □ Local Therapeutic Infusion Catheters (ClearWay RX/OTW) □ Covered Stents (iCAST)
Signature:
Customer name:
Name (print):
Title:
Date:
Telephone:
E-mail (if available):

Please return the completed CMN form to Atrium in one of three ways:

- PDF: cmn@atriummed.com
- US Fax: 1-800-880-6976
- Mail:

Office of Medical Affairs Atrium Medical Corporation 5 Wentworth Drive Hudson, NH 03051 U.S.A.