

Clinical Evaluation Form

Sales Rep: _____ Hospital: _____

Date: _____ Specialty: _____

Circ. Nurse: _____ Procedure: _____

Generator Settings: _____

(circle one)

Cutting Performance:	Very Good	Good	Acceptable	Unacceptable
Coagulation Performance:	Very Good	Good	Acceptable	Unacceptable
Appropriate Thermal Spread:	Very Good	Good	Acceptable	Unacceptable
Overall Performance	Very Good	Good	Acceptable	Unacceptable
Ease of Use:	Very Good	Good	Acceptable	Unacceptable
Bipolar Performance:	Very Good	Good	Acceptable	Unacceptable
ES Pencil Performance			Acceptable	Unacceptable
Grounding Pad Performance			Acceptable	Unacceptable

Comments: _____

Purchase recommended: Yes ____ No ____

Reasons: _____

PRINT NAME: _____

SIGNATURE: _____