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.

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