**Medical Product Evaluation Form**

**Product Information**

* **Product Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **Model Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **Manufacturer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **Date of Purchase: //\_\_\_\_**
* **Department Using the Product: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Product Performance**

* **Does the product function as expected? ☐ Yes ☐ No**
* **Rate the ease of use: ☐ Poor ☐ Fair ☐ Good ☐ Excellent**
* **How satisfied are you with the product's durability? ☐ Very Dissatisfied ☐ Dissatisfied ☐ Neutral ☐ Satisfied ☐ Very Satisfied**

**Effectiveness and Safety**

* **Has the product improved patient care? ☐ Yes ☐ No**
* **Any safety concerns observed? ☐ Yes ☐ No (If yes, please describe below)**
* **Additional Comments:**

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