SCHEDULE F -- PHYSICIAN DECLARATION FORM

In completing this Form, you may consider the patient's medical records, charts, reports, diagnostic films, medical history, or other sources of information that physicians regularly and routinely rely upon in their practice. By signing this Form, you certify that all opinions set forth below are offered to a reasonable degree of medical certainty.

1. PHYSICIAN BACKGROUND

_____ _____ _____
(First Name) (Middle Initial) (Last Name)

_____
(Office Address)

_____ _____ _____
(City) (Province) (Postal Code)

_____ _____
(Area Code & Telephone Number) (Fax Area Code & Number)

Check whether you are a/an:

☐ Orthopedic surgeon
☐ Cardiologist
☐ Neurologist
☐ Cardiothoracic surgeon
☐ Neurosurgeon
☐ Other_____

College of Physicians and Surgeons Registration Number:_____

2. PATIENT INFORMATION

State the name and birth date of the patient for whom you are providing the information contained in this Physician Declaration Form.

_____ _____ _____
(First Name) (Middle Initial) (Last Name)

_____
(Birth Date MM/DD/YYYY)

Are you one of the patient's treating physicians?

Yes No

If "Yes," state your role in the patient's medical care and treatment relative to his/her Durom Cup implant:

_____

_____

3. IMPLANT INFORMATION

State the reference and catalog numbers that correspond to the patient's Durom Acetabular Cup ("Durom Cup")

Date of Implantation (Right) _____
(MM/DD/YYYY)

Implant Reference/Catalogue Numbers _____
(if available)

Implant Lot Number _____
(if available)

Date of Implantation (Left) _____
(MM/DD/YYYY)

Implant Reference/ Catalogue Numbers _____
(if available)

4. REVISED PATIENT

Has the patient been diagnosed as requiring a revision surgery to replace the Durom Cup?

Yes No

If "Yes," please answer the remaining questions in section 4. If "No," please skip to section 8.

Date of the diagnosis: _____
(MM/DD/YYYY)

Has a revision surgery been scheduled? Yes No

If "Yes," date on which the surgery was scheduled: _____

(MM/DD/YYYY)

Has the surgery occurred? Yes No

If "Yes," date on which the revision surgery took place: _____
(MM/DD/YYYY)

Describe all reason(s) a revision surgery for the Durom Cup has been diagnosed and identify all testing or films taken and the results that support this diagnosis:

_____

_____

_____

5. UNREVISED PATIENT WHERE REVISION SURGERY IS CONTRAINDICATED

If a revision surgery has not been scheduled or will not take place, is there a medical condition that prevents the patient from undergoing a revision surgery ("Contraindication")? Yes No

If "Yes," describe the Contraindication(s) that prevent(s) replacement of the Durom Cup, and state whether the Contraindication(s) is/are temporary or permanent:

_____

_____

_____

Provide the date on which you determined that a revision surgery for the patient was Contraindicated: _____
(MM/DD/YYYY)

6. COMPLICATIONS RESULTING FROM REVISION SURGERY

☐ Check here if the patient underwent a revision surgery or surgeries to remove his/her Durom Cup(s).

If you checked the box above, and the patient sustained any of the following complications during our after his/her revision surgery, please state the date on which the complication(s) occurred:

	DATE (MM/DD/YYYY)
(a) A second revision (Right)	_____
A second revision (Left)	_____
(b) A third revision (Right)	_____
A third revision (Left)	_____
(c) Stroke that occurred within 72 hours after a revision surgery to remove a Durom Cup as a result of that surgery	_____
(d) Blood clot that occurred within 72 hours after a revision surgery to remove a Durom Cup as a result of that surgery	_____
(e) Infection in the revised hip that was diagnosed within 30 days after a revision surgery to remove a Durom Cup and was caused by that surgery	_____
(f) Permanent nerve damage resulting from a revision surgery to remove a Durom Cup	_____
(g) Death within 72 hours after a revision surgery to remove a Durom Cup that resulted from that surgery	_____

Please attach medical records to this form that confirm that the complication(s) noted above occurred. Such medical records may include, but are not limited to, operative reports, pathology reports, office records, and/or discharge summaries.

7. DECLARATION

I affirm that the foregoing representations are true and correct.

Executed on _____, 201__.

By: _____
Signature of Physician

_____
Print Name