



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 (Advanta V12)

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
- *International Fax:* see Appendix 2 on Page 9 for a list of country specific fax numbers
- *Mail:*
 - Office of Medical Affairs
 - Atrium Medical Corporation
 - 5 Wentworth Drive
 - Hudson, NH 03051 U.S.A.

FOR OUR CUSTOMERS ONLY