

**3.021 Safer Medical Device Consideration Form**

Date: \_\_\_\_\_  
Employee Name: \_\_\_\_\_  
Job Title: \_\_\_\_\_  
Department or Location: \_\_\_\_\_  
Product Description: \_\_\_\_\_  
Manufacturer: \_\_\_\_\_  
Description of how the device was tested or used: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please circle the most appropriate answer for each question:  
A = Agree                      D = Disagree                      N/A = Not applicable

**During Use**

- 1. The safety feature can be activated using a one-handed technique                      A   D   N/A
- 2. The safety feature **does not** interfere with normal use of the product                      A   D   N/A
- 3. Use of this product requires you to use the safety feature                      A   D   N/A
- 4. This product **does not** require more time to use than a non-safety device                      A   D   N/A
- 5. The safety feature works well with a wide variety of hand sizes                      A   D   N/A
- 6. This device works with the procedures in our practice                      A   D   N/A

**After Use**

- 7. The safety feature operates reliably                      A   D   N/A
- 8. The exposed sharp is blunted or covered after prior to disposal                      A   D   N/A

**Training**

- 9. The product **does not** need extensive training to be operated correctly                      A   D   N/A

Comments: Individual observation or comments should be handwritten on the reverse side of this form.