STATE OF CALIFORNIA

DEPARTMENT OF REHABILITATION (DOR)

MEDICAL DEVICE / APPLIANCE DISPENSING REPORT

DR 363 (New 08/08)

Mail or FAX completed report to:

Attn:

DOR FAX #:

Vendor:	Consumer/Patient Name:
Contact Person:	Consumer/Patient Phone #: Check if TTY ☐
Vendor Phone #:	Date Dispensed:

Device(s) Dispensed:

Goods Description:		Serial Number:
Brand:	Model:	Warranty Period:

If multiple items or warranty periods, continue below:

Good Description:		Serial Number:
Brand:	Model:	Warranty Period:
Goods Description:		Serial Number:
Brand:	Model:	Warranty Period:

Checklist: (Provider - Please complete on day device is dispensed and fax / mail to DOR office. Thank you.)

- ☐ Consumer advised that ____ post-dispensing visits over the next _____ months are included in the purchase price of the device(s).
- ☐ Consumer advised to contact provider immediately for an appointment if an adjustment to the device(s) is needed (especially if needed within the Trial-period [next ______ calendar days]).
- ☐ Consumer advised of any required follow-up appointments (especially those needed during the Trial-period). Next appointment is scheduled on: ______________________at________am/pm.
- ☐ Consumer / Patient **is** satisfied with the fitting of the device(s).
- ☐ Consumer / Patient **is not** satisfied. Explain: ____

Consumer Signature:	Date:	**If not signed by Consumer, Provider and DOR Counselor must verify & document satisfaction.**
Provider Signature:	Date:	Verified by: (e.g. appointment, phone call)
DOR Counselor Signature:	Date:	Verified by: (e.g. appointment, phone call)

Save As | Print | Clear Form