VA0000001

PRINT

University of Connecticut
Health Center

Office of Materials Management

PRODUCT APPROVAL FORM: MM-7B

Project Type:	Date:
Item (s) Trialed:	Trial Date:

Over-All Product Performance Ratings:

1. **Did product meet Clinical needs:**

   Yes ☐ **No** ☐ **Not Applicable** ☐

2. **Over-all performance of this product: Acceptable** ☐ **Unacceptable:** ☐ *

3. **Would you recommend the use of this product? Yes** ☐ **No** ☐ *

Comments: *	
Department Director/Manager's Name: Signature:	 Date:
Physician's Name: Signature:	 Date:
Value Analysis Facilitator: Signature:	 Date:
University Director of Materials Management Signature:	Date: