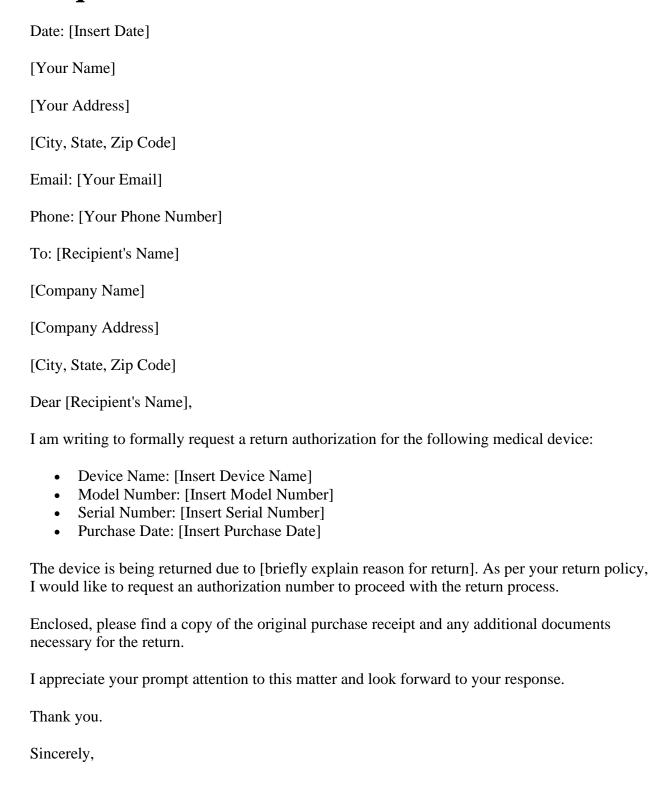
Medical Device Return Authorization Request



[Your Name]