Implant registration form

This registration form must be completed and returned to your closest Cochlear™ office or distributor by mail or fax (see contact details below) immediately following implantation to validate product warranty.

- **Cochlear Limited** 1 University Avenue, Macquarie University NSW 2109, Australia, Fax 61 2 9428 6352
- **Nihon Cochlear Co Ltd** Ochanomizu-Motomachi Bldg, 2-3-7 Hongo, Bunkyo-Ku, Tokyo 113-0033, Japan, Fax 81 3 3817 0245
- **Cochlear (HK) Ltd** Unit 1810, Hopewell Centre, 183 Queens Road East, Wan Chai, Hong Kong SAR, Fax 852 2530 5183
- **Cochlear Ltd** (Singapore Branch) 6 Sin Ming Road, #01-16 Sin Ming Plaza Tower 2, Singapore 575585, Fax 65 6451 4105
- **Cochlear Korea Ltd** 1st floor, Cheongwon building, 828-5, Yuksam dong, Kangnam gu, Seoul, Korea, Fax 82 2 533 8408
- **Cochlear Medical Device (Beijing) Co Ltd** 2208 Gemdale Tower B, 91 Jianguo Road, Chaoyang District, Beijing 100022 P.R. China, Fax 86 10 5909 7900
- **Cochlear Medical Device Company India (P) Ltd** Platina Building, Ground Floor, Plot No. C-59, G-Block, BKC, Bandra (E), Mumbai – 400 0051.
  Ph : +91 22 6112 1111 Fax : +91 22 61121100

Please print clearly. *Required fields

Implant details

Type of implant* *(please tick box for implant type you want to register)*

○ Cochlear™ Nucleus® Implant ○ Cochlear™ Baha® Implant ○ Vistafix® Implant

FOR NUCLEUS IMPLANTS ONLY

Serial # (for Nucleus Implants) or Lot # (for Baha and Vistafix Implants)*	Surgery date* *Example: 15-JAN-2010*	Which side?* *(please tick correct box)*	Number of electrodes OUTSIDE the cochlea?* Left	Right	Has the recipient had a previous implantation on this side?* *(please tick correct box)*
Place sticker from implant box here OR fill in number manually	DD-MMM-YYYY	L R			Y N
Place sticker from implant box here OR fill in number manually	DD-MMM-YYYY	L R			Y N

Recipient details

Surname*

Given names*

Gender* ○ Male ○ Female **Date of birth*** Day Month Year *Example: 15-JAN-1999*

Address Number Street

Town / City* Zip/Postal code

State / Province Country*

Phone Country code - Area code - Number

E-mail address

Parent or guardian details *(if recipient is under 18 years old)*

Surname*

Given names*

Contact details are the same as for the child* ○ Yes ○ No *(please fill in details below)*

Phone Country code - Area code - Number

E-mail address

Surgery centre

Organisation*

Town/City* **Country***

Implant surgeon* Title Surname Given names

Audiology centre *(if known)*

Organisation

Town/City **Country**

Audiologist Title Surname Given names

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