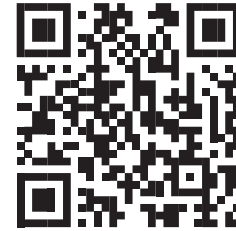


# Product Evaluation Form

Please fill in the information below and email a picture of completed form to: [info@airwayinnovations.com](mailto:info@airwayinnovations.com)

OR



Scan to fill out Evaluation Form

| GENERAL INFORMATION   |
|---|
| Today's Date (MM/DD/YYYY):  |
| Patient's Age:  |
| Patient's Gender: <input type="radio"/> Male <input type="radio"/> Female           |
| Type of Procedure:  |
| Product LOT #:  |
| Airway used with AERIS™ device: <input type="radio"/> OPA <input type="radio"/> NPA |

| CLINICAL PERFORMANCE   |
|--|
| <p>What do you currently use to deliver oxygen during deep I.V. sedation procedures?</p> <p><input type="radio"/> Nasal Cannula <input type="radio"/> Face Mask <input type="radio"/> Other: _____</p>   |
| <p>How did the AERIS Airway™ ETCO<sub>2</sub> waveform compare to what you currently see?</p> <p><input type="radio"/> Better <input type="radio"/> Same <input type="radio"/> Worse</p>   |
| <p>How did the AERIS Airway™ deliver oxygen compared to the oxygen delivery device you typically use?</p> <p><input type="radio"/> Better <input type="radio"/> Same <input type="radio"/> Worse</p>   |
| <p>Does your patient monitor offer FIO<sub>2</sub> readings? <input type="radio"/> Yes <input type="radio"/> No</p>  |
| <p>If "Yes" to the question above, when using the AERIS Airway™, was FIO<sub>2</sub>:</p> <p><input type="radio"/> Higher than what I normally experience</p> <p><input type="radio"/> Similar to what I normally experience</p> <p><input type="radio"/> Lower than what I normally experience</p> <p><input type="radio"/> Do not know</p> |
| <p>Rate your experience using the AERIS Airway™: <input type="radio"/> Very Satisfied <input type="radio"/> Satisfied <input type="radio"/> Dissatisfied</p>   |
| <p>Based on your experience, would you be inclined to use the AERIS Airway™ for your deep I.V. sedation procedures? <input type="radio"/> Yes <input type="radio"/> No</p>   |

| PROVIDER INFORMATION     |        |
|--------------------------|--------|
| Clinician's Name:        |        |
| Clinician's Signature:   |        |
| Name of Hospital/Clinic: |        |
| Email:                   | Phone: |