



DEVICE DEMO AGREEMENT

hipGRIP® kneeGRIP™ kneeGRIP II™ thighGRIP™ legGRIP™ X-Guide™

The Demo Agreement is as follows: ONE-WEEK EVALUATION PERIOD (7 days). Shipping days do not count against your trial period. Beginning the 8th day, your hospital will be charged \$50.00 per day. The hospital will be financially responsible for shipping charges and any lost or damaged parts. **Shipping is to be FedEx 2-Day Economy (BOTH directions) and packed in a box to protect the carrying case and/or parts from damage during shipping.**

SunMedica Corporation, located at 1661 Zachi Way, Redding, California 96003, is providing you with the orthopedic equipment indicated above (the "Equipment") solely for the purpose of evaluation to assess the appropriate use and functionality of the Equipment and determine whether or not and when to use, order, purchase or recommend the Equipment in the future. The equipment is being provided to you at no charge for a reasonable amount of time to allow an adequate evaluation and must be returned on or prior to the date set forth below (the "Evaluation Period"). In no event will the "no charge" Evaluation Period exceeds 7 days. Your facility will be charged Fifty Dollars (\$50.00) per day for the Equipment evaluated after the 8th day. Title to the equipment shall at all times remain with SunMedica.

Your facility will be financially responsible for the return of the Equipment to SunMedica upon the conclusion of the Evaluation Period. SunMedica shall maintain Product Liability and General Comprehensive insurance at all times in the amount of One Million Dollars (\$1,000,000.00) per claim. Your facility is responsible for the Equipment during the Evaluation Period and agrees to return the Equipment in the same condition as was delivered to you, subject to normal wear. You are also responsible for using the Equipment for its intended purpose in accordance with its instructions for use. If the Equipment is used for anything other than the intended use, then SunMedica does not make any representation or warranty with respect to the use of the Equipment or to the safety of the equipment either expressed or implied. Should you wish to purchase the Equipment from SunMedica, your sales representative will assist you.

SHIP TO:

Hospital Name _____
Address _____
City _____ State _____ Zip _____
OR Contact Person _____ Phone# _____ Fax# _____

DATE THE DEVICE NEEDS TO ARRIVE BY: _____

BILL TO:

Accounts Payable _____
Address _____
City _____ State _____ Zip _____
AP Contact Person _____ Phone# _____ Fax# _____

PURCHASE ORDER NUMBER _____ Terms: Net 30 day a finance charge of 2% will begin on the 31st day. I, (Print Name & Title) _____ am an authorized agent and have read and agree to the above stated terms.

SIGNATURE: _____ **DATE:** _____

TO EXPEDITE YOUR REQUEST: 1.) FAX agreement 2.) CALL to verify that it's been received.

www.sunmedica.com

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