ORGANIZATION LETTERHEAD

DATE OF REQUEST

*Optional: PATIENT NAME

To whom it may concern

I am formally requesting the donation of INSERT SJM PRODUCT HERE as part of the patient assistance program for an indigent patient. This patient does not have health insurance nor do they qualify for government assistance programs. The product donation will consist of only patient necessary equipment. Any unused product will be returned to St. Jude Medical.

Both implanting physician and hospital/facility will be donating their services for this patient's procedure.

Sincerely

SIGNATURE OF IMPLANTING PHYSICIAN OR AUTHORIZED HOSPITAL REPRESENTATIVE

NAME OF SIGNER SPELLED OUT

TITLE