Patient Assistance Program Application

The Covidien Patient Assistance Program is available to assist people who do not have the financial resources to support their medical supplies needs. Please complete the following to initiate your request.

SECTION 1: Recipient Information for Wound Care or Incontinence Products

First and Last Name of Patient:	**Date:**
Address: (city, state, zip code)	**Email Address:**
Phone Number:	**Previous Support from Covidien:** ____ **Yes** ____ **No** **Previous Supplier of Product:** ____________________
Specific Product(s) Requested (include product number, if known, and description):	

SECTION 2: Acknowledgement and Confirmation

I understand that by completing and submitting this form, I am confirming and acknowledging that I will not seek reimbursement under any state or federal program (including Medicare/Medicaid) for these products. I understand that Covidien has the right to review and approve requests based on its sole discretion and timetable, and that all decisions are final. I also understand that I am entitled to a one-time donation, as quantities are limited. The above information is, to the best of my knowledge, true and correct.

Patient Signature:

Application Submission Process

Completed applications may be sent to:

Vice President, Civic Affairs
Corporate Communications
Covidien
15 Hampshire Street, Building 4
Mansfield, MA 02048

Applications may also be submitted online to Philanthropy@Covidien.com