

## Surgeon Certification of Free Health Care

**Note: A signed copy of this Certificate is required for any requests submitted to the Medtronic Spinal and Biologics business. Please attach this Certificate to your request prior to submission.**

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By checking the box below, I, the undersigned, certify that I will not bill the patient named in this request form, Medicare, Medicaid, any insurer, or any other individual or third party payor for my services related to the surgery described in the Medtronic Spinal and Biologics Patient Assistance Product Charitable Donation Request Form that is submitted for the patient.

**Check this box to certify acceptance of the statement above:**

Print organization name	
Print your name	
Print title	
Phone number, including area code	
Signature	
Date	

If you have any questions about this Certificate, please notify the Medtronic Office of Ethics & Compliance by calling 763-505-2050 or by sending an email to [rs.grantsanddonations@medtronic.com](mailto:rs.grantsanddonations@medtronic.com).

## Hospital Representative Certification of Free Health Care

**Note: A signed copy of this Certificate is required for any requests submitted to the Medtronic Spinal and Biologics business. Please attach this Certificate to your request prior to submission.**

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By checking the box below, I, the undersigned, certify that the hospital identified in this request form, will not bill the patient named in this request form, Medicare, Medicaid, any insurer, or any other individual or third party payor for any hospital services and products, including any products donated by Medtronic Spinal and Biologics, related to the surgery described in the Medtronic Spinal and Biologics Patient Assistance Product Donation Request Form.

**Check this box to certify acceptance of the statement above:**

Print organization name	
Print your name	
Print title	
Phone number, including area code	
Signature	
Date	

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## Medtronic Certificate of Compliance

**Note: A signed copy of this Certificate is required for any requests submitted to the Medtronic Spinal and Biologics business. Please attach this Certificate to your request prior to submission.**

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By checking the box below, I, the undersigned, certify that to the best of my knowledge, the following statements are true with respect to this request:

1. The receiving organization, its personnel, and I have not, implicitly or explicitly, solicited the requested donation in exchange for an agreement to purchase, use, order, or recommend Medtronic products.
2. No Medtronic representative implicitly or explicitly offered a donation to the receiving organization, its personnel, or me to purchase, use, order, or recommend Medtronic products or to reward prior purchases, uses, orders, or recommendations of Medtronic products.
3. The requested donation would not result in more than an incidental private benefit to a health care provider who uses, orders, or recommends Medtronic products.
4. All of the information included on and documentation attached to this request form by the requester and/or receiving organization is accurate.

**Check this box to certify acceptance of the statements above:**

Print organization name	
Print your name	
Print title	
Phone number, including area code	
Signature	
Date	

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