Warranty Claim Form

AML Office Use Only
Date completed form received:
WARRANTY CLAIM NO:

Date: _____

Tech / Subcontractor / Dealer Details

Business Name: _____ Phone: _____
Warranty Contact: _____ Email: _____
Address: _____

Product Details

Unit Serial #: _____
(No claims will be processed unless serial # of unit is supplied)
Model: _____
End User Name: _____
Photos of the fault must be supplied ☐

Invoice or P/Slip # and Date Sold: _____
End User Purchase Date:* _____
*required if applicable to claim
Battery Date of Manufacture _____

If applicable, confirm the client is under the maximum user weight for the equipment: _____

How was the product being used when the fault occurred?

Has the complete product failed or only parts of it?

Describe the fault and how it was first identified.

Has the equipment/part sustained any impact?

Requested Parts / Equipment:

Please advise contact at AML if already discussed / made contact: _____

Email form to: **customercare@alliedmedical.co.nz**
COMPLETING THIS FORM DOES NOT VALIDATE THIS WARRANTY CLAIM

AML Office Use Only:
Resolution:
Equipment / Part sent on p/s: Date Sent:
Equipment / Part #:
AML Tech Report:
Tech Name: Warranty Confirmed: ☐ Warranty Declined: ☐
Reason Warranty has been declined:

AML Staff Member: