



**CUSTOM
ULTRASONICS
INC.**

FLOPPY DISK REPLACEMENT FORM

ALL INFORMATION MUST BE COMPLETED
FAX COMPLETED FORM TO (215) 364-7674
PHONE (215) 364-1477 WITH QUESTIONS

CONTACT NAME _____ FACILITY NAME: _____

DEPARTMENT: _____

SHIP TO ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

SYSTEM 83 PLUS™ INFORMATION:

REASON FOR DISK REPLACEMENT: _____

SYSTEM SERIAL NUMBER: (Found on plate near power cord on back of unit)

NUMBER OF PROCESSING CHAMBERS (BAYS) 1 -- 2 -- 3 -- 4

PROGRAM VERSION (From the opening screen simultaneously press the "Alt" and "X" keys. The DOS prompt will then show one of the following numbers):

A:\CU013003 A:\CU071097 A:\CU090396

C:\CU013003 C:\CU071097 C:\CU090396

_____ (other - please specify)

PRESS THE SMALL RECTANGULAR BUTTON ON THE FLOPPY DRIVE, DOES A FLOPPY DISK POP OUT?

Yes No

DOES YOUR SYSTEM 83 Plus HAVE OUR HARD DRIVE/DATABASE OPTION ?:

Yes No

*HIGH LEVEL DISINFECTANT NAME: _____

*REQUIRED DISINFECTANT IMMERSION TIME _____ MIN

CHOOSE ONE

- 14 Day 2% Glut. OPA Product
 Other _____ (Describe)

DOES YOUR SYSTEM 83 Plus HAVE OUR TEMPERATURE CONTROL OPTION? : Yes

(Check "YES" **ONLY** if you have 2 small thermometers visible in the lower right hand corner of the monitor screen during System operation.) No (If No, Temp listed cannot Exceed 20 °C/ 68° F)

*REQUIRED IMMERSION TEMPERATURE: _____ °F or _____ °C ¶ **TEST CYCLE PERFORMED (req.)**
PRINT OUT VERIFICATION MUST BE ATTACHED

*REQUIRED # OF WATER RINSES AFTER DISINFECTION CYCLE --- 2 or 3

IS THE RECOMMENDED TERGAL BEING USED? Yes Or Other Detergent Name _____

DO YOU HAVE AUTOMATIC DETERGENT INJECTION ?: Yes No

*QUANTITY OF DETERGENT USED IN EACH WASH CYCLE: _____ OZ

*** NOTE: Always indicate the chemical type, immersion time and temperature you are intending to use. Custom Ultrasonics, Inc. does not endorse any chemical germicide or other detergents. Any chemical germicide chosen is the sole responsibility of the facility placing the order for the program disk. The customer must follow the label claim of the chosen germicide and published guidelines. CU must confirm via FORM 7.40. DETERGENTS OTHER THAN TERGAL MUST BE VALIDATED BY USER/ FACILITY FOLLOWING MFG.GUIDLINES.**

SHIP BY: Next Day Air Second Day Air UPS Ground

Purchase Order# _____ (Part # 26026) consult price list for pricing.

PERSON PREPARING FORM: _____

CONTACT PHONE NUMBER --**IMPORTANT**--: _____

SIGNATURE: _____ Print name: _____ DATE: _____

(of person making request)

Programming completed by: _____ Programming Confirmed By: _____ Ship Date: _____

¶ **NOTE: TEST CYCLE PRINT OUT VERIFICATION MUST ACOMPANY THIS FORM TO DHR FILE.**

Prepared By: Signature on File
Approved By: Signature on File
QA Release: Signature on File