eureka medical
THE INVENTOR NETWORK

Medical Invention Review Registration Form

First Name: _____MI: _____ Last Name: _____

Address: _____

_____

City: _____ State:_____ Zip:_____

Daytime Phone:_____ Evening Phone:_____

Fax: _____ E-mail:_____

Join The Medical Inventor Network and receive quarterly eNewsletter MedInvent with latest in medical device trends and updates on targeted medical innovation searches **_____ yes _____no**

Multiple Inventors: (Check here is applicable) _____
If more than one person was involved in the creation of the idea (s) you plan to present, the primary contact for the inventor team should be listed above. We will obtain the information for the other team members when we call to finalize your registration.

How did you hear about us?
(Please check all that apply and provide the name of the source if possible)

☐ Article or news story	☐ Referral by BIG	☐ Website - Med Invent
☐ Inventor organization	☐ Referral	☐ Inventors Organization
☐ Magazine ad	☐ Website - General	☐ None given
☐ Newpaper ad	☐ Website - InvNetwork	☐ Other, specify

Other: _____

Select a Roadshow Location:

DATE:_____

LOCATION:_____

PREFERRED TIME:_____

One Burlington Business Center, 67 South Bedford Street, Suite 400 W, Burlington, MA 01803
Phone: 781-229-5878 - Fax: 617-812-0094 - email: info@EurekaMed.com

INVENTION INFORMATION

Please provide a name and brief description of your invention:

Area of Specialization (please check the appropriate box)

☐ Cardiovascular	☐ General Medicine	☐ Bioengineering	☐ Other
☐ Orthopedics	☐ Critical Care Nursing	☐ Rehabilitation	☐ OB/GYN
☐ Neuro/Spinal	☐ General Nursing	☐ Dental	☐ Professional Medical Inventor
☐ Peripheral Vascular	☐ Emergency	☐ Home Care	☐ Amateur Medical Inventor
☐ Urology	☐ Paramedic	☐ Respiratory	
☐ Gastroenterology	☐ Surgical Tech	☐ ENT/Otolaryngology	
☐ Plastic Surgery	☐ Chiropractic	☐ Nephrology	
☐ Dermatology	☐ Physical Therapy	☐ Ophthalmology	
☐ Anesthesia	☐ Medical Product Design	☐ Pathology	

Category of New Product (please check the appropriate boxes if applicable)

☐ Consumer Healthcare	☐ Medical Supplies
☐ Critical/Intensive Care	☐ Preventative
☐ Diagnostic	☐ Rehabilitation
☐ Emergency Care	☐ Self Treatment
☐ Homecare	☐ Surgical Devices
☐ Dental Supplies	☐ Surgical Implants
☐ IV and Fluid Management/ Automation	☐ Other (please explain)

Other: _____

Benefits of New Product (please check the appropriate boxes if applicable)

☐ Less Invasive	☐ Cost savings
☐ Self Monitoring	☐ Improved monitoring and Information trackir
☐ Improved Clinical Outcome	☐ debottlenecks ER or OR
☐ Shorter Recovery Time	☐ Process improvement
☐ Time Savings	☐ Reduces risk of injury to hospital staff
☐ Patient Convenience	☐ Total solution vs. partial solution
☐ Less Frequent Consultation Visits	☐ Other (please explain)
☐ Reduced Risk of Mortality or Complications	
☐ Reduce Preventable Errors	
☐ Sterility or safety enhancement	
☐ Communication and Organization	

Other: _____

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MEPS Major Disease Category (please check the appropriate box if applicable)

_____ Cancer	_____ Diabetes	_____ Emphysema
_____ High Cholesterol	_____ Hypertension	_____ Stroke
_____ Ischemic Heart Disease	_____ Bone and Joint Reconstruction	_____ Back Problems
_____ Asthma	_____ Gall Bladder	_____ Stomach Ulcers
_____ HIV / AIDS	_____ Alzheimer's Disease	_____ Arthritis

_____ Other (please explain) _____

Expected FDA Regulatory Requirements (Please check yes or no)

FDA 510 (k) Filing for Substantial Equivalence	_____ yes	_____ no
FDA Pre-Market Approval (PMA)	_____ yes	_____ no
Class 1 Medical Device	_____ yes	_____ no
Class 2 Medical Device	_____ yes	_____ no
Class 3 Medical Device	_____ yes	_____ no

Other Regulatory Issues:_____

Work done to date, if any:_____

Intellectual Property Position

How far along are you in the development process?

☐ Description	☐ Idea Stage	☐ CD-ROM	☐ Patent Info
☐ Rough Prototype	☐ Photos	☐ Drawings	
☐ Advanced Prototype	☐ Video	☐ Market research	

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(Please check yes or no)

Patents need to be filed: _____ yes _____ no

Intellectual Property Position continued (Please check yes or no)

Patents filed: _____ yes Date:_____ _____ no

Patents granted: _____ yes Date:_____ _____ no

Sole ownership by presenting inventor: _____ yes _____ no

Joint ownership shared with presenting inventor: _____ yes _____ no

Names of shared inventors: _____

Institutions have rights to Intellectual Property: _____ yes _____ no

Names of Institutions: _____

Need help with Intellectual Property strategy: _____ yes _____ no

Prior Art Search has been done _____ yes _____ no

*** All joint owners and institutions with rights to intellectual property will have to sign the entry agreement.

Medical Inventor's Background:

Profession: _____Years of Experience:_____

Education;_____

Number of Inventions to Date:_____

Other Information you would like us to know:_____

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