

## ***SURGICAL GLOVE EVALUATION***

(Circle One Currently Using)

**Current Glove**

Biogel/Protegrity/PF Latex  
Dermaprene/PF Synthetic  
Latex Ortho

(Circle One Being Evaluated)

**Allegiance Brand**

Protegrity SMT  
Esteem SMT  
Ultrafree Max (Ortho)

**Allegiance  
Glove Size**

	Excellent	Good	Acceptable	Poor
Fit/Comfort	<input style="width: 100%; height: 20px;" type="text"/>	<input style="width: 100%; height: 20px;" type="text"/>	<input style="width: 100%; height: 20px;" type="text"/>	<input style="width: 100%; height: 20px;" type="text"/>
Tactile Sensitivity	<input style="width: 100%; height: 20px;" type="text"/>	<input style="width: 100%; height: 20px;" type="text"/>	<input style="width: 100%; height: 20px;" type="text"/>	<input style="width: 100%; height: 20px;" type="text"/>
Strength/Durability	<input style="width: 100%; height: 20px;" type="text"/>	<input style="width: 100%; height: 20px;" type="text"/>	<input style="width: 100%; height: 20px;" type="text"/>	<input style="width: 100%; height: 20px;" type="text"/>

**Clinical Acceptability:** (Barrier Protection, Sterility, Functionality)

Allegiance gloves are clinically acceptable       Yes       No

**Remarks:**

**Staff Position:**

Surgeon \_\_\_\_\_      Resident/Fellow \_\_\_\_\_      PA \_\_\_\_\_  
RN \_\_\_\_\_      Surgical Tech \_\_\_\_\_      Other \_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name