MEDICAL INFORMATION REQUEST FORM

DO NOT use this form for Adverse Events or Product Quality Complaints

To Report an Adverse Event: Email: IBSA@linical.accelovance.com or call 800-587-3513

Date: ____ / ___ / ___

INFORMATION REQUESTED BY:

First Name: _____ Last Name: _____

Requester's Role: ☐Physician ☐Nurse ☐Pharmacist ☐PA ☐NP

Other: _____

CONTACT INFORMATION

Phone:_____ Fax: _____

Email:_____

ADDRESS

Street: _____ City:_____

State:_____ Zip Code: _____ Country: _____

ORGANIZATION

Organization Name: _____

Phone:_____ Fax: _____

Email:_____

ADDRESS

Street: _____ City:_____

State:_____ Zip Code: _____ Country: _____

WHAT ARE YOU REQUESTING? (Please be specific when asking for information.)

_____

_____

_____

_____

_____

_____

Signature:_____ Date:_____ / ___/ ___

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