MEDICAL INFORMATION REQUEST FORM

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

To Report an Adverse Event: Email: Medinfo@ibsapharma.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.)

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Signature: ______________________________ Date: _____ / ___ / ___

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