

MEDICAL INFORMATION REQUEST FORM

For use by Health Care Professionals requesting Medical Information related to Ferring Pharmaceuticals marketed products.



DATE

DD		MMM			YYYY				

CONTACT INFORMATION

NAME:		TEL.NO:
INSTITUTION/ADDRESS:		
CITY:	PROVINCE:	POSTAL CODE:

MEDICAL/SCIENTIFIC PRODUCT INQUIRY

PRODUCT NAME :

Please identify Medical Information Request below:

I am requesting medical information for the following reason:

- | | |
|--|--|
| <input type="checkbox"/> Scientific Interest | <input type="checkbox"/> Presenting to Peers |
| <input type="checkbox"/> Resident Training | <input type="checkbox"/> Conference |
| <input type="checkbox"/> Publication Review | <input type="checkbox"/> Other: _____ |

I hereby certify that the information requested above is unsolicited by Ferring Pharmaceuticals.

Please forward requested information via:

ALTERNATE CONTACT NAME (if other than yourself):

Fax: _____ **E-mail:** _____

SIGNATURE

SEND COMPLETED FORM TO MEDICAL INFORMATION AT FERRING PHARMACEUTICALS

E-mail: medicalinformation@ferring.com OR Fax: 416-493-1692

If you are not the addressee indicated (or responsible for the delivery of the message to such person), please do not copy or deliver to anyone. In such case, please destroy this message, please advise the sender immediately. Opinions, conclusions and other information in this message represent the opinion of the sender and do not necessarily represent or reflect the views and opinions of FerringPharmaceuticals.