MEDICAL INFORMATION REQUEST FORM

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

FERRING PHARMACEUTICALS

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:

- ☐ Scientific Interest
- ☐ Resident Training
- ☐ Publication Review
- ☐ Presenting to Peers
- ☐ Conference
- ☐ 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