Ocular Therapeutix™ | MEDICAL AFFAIRS

Medical Information Request Form

Ocular Therapeutix Representative Contact Information

Name:

Phone:

Email:

Region/Territory:

Healthcare Professional Contact Information

Name:

Title:

Hospital Affiliation:

Street Address:

City:

State:

Zip Code:

Phone:

Fax:

Email:

Inquiry Details

Product:

Inquiry Text:

Delivery:

Rush Delivery: **YES** ☐ **NO** ☐

Digital Signature:

☐ I understand that checking this box constitutes my legal signature certifying that, this is an unsolicited request for medical information by a healthcare professional, and that the request is captured as the healthcare professional has intended.

Instructions:

1) Adverse events or product quality complaints should not be reported using this form.
2) Please complete all fields of the form.
3) Email the completed form to **ocutx.medinfo@propharmagroup.com**.