

Exeltis Women's Health Sample Request Fax Form

To receive your samples of Exeltis Women's Health products, complete this form and fax it, along with a copy of your state license, to:

Exeltis Women's Health Sample Order Fulfillment Warehouse
Fax: 614-652-8275



Exeltis USA, Inc.
180 Park Ave., Suite 101
Florham Park, NJ 07932

P: 844-718-0831 • F: 614-652-8275
www.exeltisusa.com

Your shipment of professional samples may only be sent to your office address.

PLEASE NOTE: In compliance with the Prescription Drug Marketing Act regulations, incomplete request forms cannot be processed and samples will not be forwarded.

PRACTITIONER INFORMATION

(Please print)

Professional Designation (Check One): MD DO NP PA

First Name: _____

Last Name: _____

Address 1: _____

Address 2: _____

(Samples will not be issued or delivered to a PO Box; please provide your office street address)

City: _____ State: _____ Zip Code: _____

Telephone #: _____

Fax #: _____

E-Mail Address: _____

State License Number: _____ Exp. Date: _____

PRODUCT INFORMATION

Select the samples you wish to receive. Please allow 3-5 business days for delivery.

- | | |
|--|---|
| <input type="checkbox"/> ITEM 0642-0093-03 VitafoI®-Ultra, 21 Units | <input type="checkbox"/> ITEM 0642-0070-03 VitafoI®-One, 21 Units (N.Y. Only) |
| <input type="checkbox"/> ITEM 0642-0125-03 VitafoI® Gummies, 7 Units | <input type="checkbox"/> ITEM 0642-0075-03 Select-OB®+DHA, 21 Units |
| <input type="checkbox"/> ITEM 0642-0096-01 VitafoI® Fe+, 21 Units | <input type="checkbox"/> ITEM 0642-0207-03 Strovite® One, 21 Units (N.J. Only) |
| <input type="checkbox"/> ITEM 0642-0094-03 VitafoI®-Nano, 21 Units | |

PLEASE CIRCLE BEST TIMES TO RECEIVE SAMPLES: MON- AM/PM TUE-AM/PM WED-AM/PM THURS-AM/PM FRI-AM/PM

I certify I am a licensed practitioner eligible to request, receive, prescribe and dispense these samples at the location above. If I am a Nurse Practitioner or Physician Assistant, I certify I am authorized and eligible, in the state in which I am now practicing, to request and receive these samples and I have my supervising Physician's approval to do so. I have requested these samples for the medical needs of my patients and I will not sell, resell, trade, barter, return for credit or seek third-party reimbursement for them.

Practitioner's Signature
(original signature required - no stamps)

Date