

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 ocular@medinfodept.com.