MEDICAL INFORMATION REQUEST FORM

Please complete this form and send to Telix Medical Information within 24hrs of awareness to MedInfo@telixpharma.com or use the Submit Form button below.

1. Contact Information

Name & credentials of HCP		**HCP Type Specify Other**	HCP Type - Select
Institution Name		**Contact Email**	
Address (Street, city, state, zip/post code, country		**Contact number (with area code)**	

2. Medical Inquiry

Please provide detailed information regarding the inquiry

3. Signature

Request is not valid without HCP's signature. If signature cannot be obtained, ensure HCP is in cc' of email sent to MedInfo. Your signature confirms that your question was not prompted or solicited by anyone at Telix Pharmaceuticals and that the wording above accurately states your question. If signature could not be obtained, ensure HCP is in cc' when emailing MIR Form to MedInfo@telixpharma.com

HCP Name (print)	Signature	Date (dd-mmm-yy)
Telix Representative Name (print)	**Signature**	**Date (dd-mmm-yy)**

SUBMIT FORM

If reporting safety information or an adverse event, contact pharmacovigilance@telixpharma.com directly within 24 hours of awareness

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