
## Clinic Information

| | | | |
|---|---|---|---|
| Clinic Name | | | |
| Address Line 1 | | | |
| Address Line 2 | | | |
| City/Town | | Post Code | |
| County | | Country | |
| Phone Number | | Fax Number | |
| Email | | | |

☐ Check this box if you would like a Baxalta medical person to demonstrate the device for your center

## Clinic Administrator Information

| | | | |
|---|---|---|---|
| First Name | | Last Name | |
| Phone Number | | | |
| Email | | | |

☐ Check this box if you would like the Clinic Administrator to have Patient Access

## Requestor

| | | | |
|---|---|---|---|
| First Name | | Last Name | |
| | | Signature | |

## For Baxalta Admin Purpose Only

| | | | |
|---|---|---|---|
| Verified by | | Baxalta Customer # | |
| Date | | Signature | |