ALIMERA SCIENCES
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MEDICAL INFORMATION REQUEST FORM

Name:	Request Date:
Title / Sub-specialty:	
Institution:	
Address:	
City: State/Province: ZIP/Postal Code: Country:	
Phone: Fax: Email:	
Requestor's Signature:	

With this signature above, I confirm this request for information was unsolicited.

Preferred Method of Contact: □ Phone □ Fax □ Email

Request/Question *(Please be detailed to ensure an accurate and timely response)*

If requesting data slides for personal use and/or scientific exchange. I understand that materials received may be used in scientific presentations but are not for distribution. I will disclose that I am not speaking on behalf of Alimera Sciences.

□ By checking this box I confirm that I agree and understand the statement above.

Special Area of Interest: □ DME □ Other_____

Do you treat DME? □ Yes □ No

AREA BELOW FOR OFFICE USE ONLY

Request sent by: (name) / (position)
Response from Medical Affairs Department:
Circle all applicable - Telephone Email Mailed Letter In Person

Medical Affairs Representative Responding to Request:
Name:
Signature:
Date of Response: