



# Sample Request Form

**Instructions:** Complete the required information below and fax to (888) 892-1638, or mail this completed request to the address below. Upon receipt of this request and license verification, samples will be processed for shipment.

**BiDil® Professional Samples Program**

1155 Charles St – Suite 165  
Longwood, FL 32750  
Customer Service: (888) 417-7153

*For Quickest Service*

**Fax to: (888) 892-1638**

Physician Name: \_\_\_\_\_

(Please print)                      *First Name*                      *Last Name*

State License Number: \_\_\_\_\_ Professional Designation: \_\_\_\_\_

Name of Practice: \_\_\_\_\_

Address: \_\_\_\_\_ Suite #: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Please check samples requested:



4 Bottles of 12 Tablets

6 Bottles of 12 Tablets

By signing this form I certify that I have requested the items listed above in the quantities designated. I further certify that I am a licensed practitioner eligible to receive and prescriber these samples. If I am a Nurse Practitioner or Physician Assistant, I certify that I am authorized and eligible in the state within which I am currently practicing to request and receive these samples and that I have my supervising Physician's approval to do so. My signature on this form certifies that I recognize that sample products are for the medical needs of my patients and will not be sold, traded, bartered, returned for credit or utilized to seek or obtain reimbursement.

\_\_\_\_\_  
Licensed Practitioner Signature  
*No Stamps Accepted*

\_\_\_\_\_  
Date

\_\_\_\_\_  
NitroMed Representative Name

\_\_\_\_\_  
Territory Name