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Please complete the form below

Distributor information	
Company name:	
Address:	
Representative:	
Position:	
Telephone number:	
e-mail address:	

End user / Medical Facility information				
Hospital name(s):				
Physician(s) / Neurosurgeon(s):				
Address(es):				
Date of request:				
Item number:				
Product name:				
Purpose of use: (clinical use, show, repair / loaner, congress, cadaver)	to show ☐	clinical use ☐	repair / loaner ☐	congress ☐
Period / Duration:	• From: • To:			
Current cranial system in use:				
Current retractor system in use:				
Active competitor in facility:				
Is this a current customer:				
Budget approved Y / N (Available funds for the new investments in the facility?)				

Notes / Comments: - Why is it important?	

Note: This document is for informational purposes only. It has been created digitally and is valid without a signature.

SUBMIT

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