Medical Information Request Form

Review and submit the completed form to:

medinfo@heliusmedical.com

First Name: Last Name:

Degree: Specialty: Title:

Institution:

Address:

City: State: Zipcode:

Email address: Phone:

Question(s): No symbols, shorthand or acronyms please

This form is for the documentation and transmission of unsolicited medical inquires to Helius Medical, Inc Medical Information. I certify that I am the requestor; I have requested the information described above and I confirm that this inquiry was not solicited in any manner by a representative.

I also acknowledge that the information I provide will be stored in a database which is the property of Helius Medical, Inc for the purposes of processing this Medical Information request.

Requestor Signature: ____ Date:

Field Personnel: By submitting this form, I certify that this is an unsolicited request for medical information.

Name: Position: Date:

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