Document: FRM 7.5-7-1 Revision: A Department: Medical Affairs	**Title: Medical Information Request Form**	Helius Medical, Inc

Reference: QSP 7.5-7 Unsolicited Requests for Information.

Instruction: 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: _____