

# Medical Information Request Form

## REQUESTOR

FULL NAME: \_\_\_\_\_

MD    DO    PharmD    RPh    PA    NP    RN    Other

Institution: \_\_\_\_\_

Address: \_\_\_\_\_

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

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

E-mail: \_\_\_\_\_

## PLEASE CHECK PREFERRED METHOD OF INFORMATION DELIVERY

E-mail    Phone    Fax    Mail

## INFORMATION REQUESTED

---

---

---

---

---

---

---

---

I acknowledge that I have requested information described above to be sent to me by GTx Medical Affairs. I also acknowledge that the information I provide to GTx will be stored in a database which is the property of GTx, for the purposes of processing this Medical Information request.

**SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_  
(Required)

## INSTRUCTIONS

**Fax request to 877-362-7596 or e-mail request to [medinfo@gtxinc.com](mailto:medinfo@gtxinc.com)**

GTx representative \_\_\_\_\_