Channel Medsystems Medical Information Request Form

Mail or email this form to: medinfo@channelmedsystems.com

Department of Medical Affairs
Channel Medsystems
2919 7th Street
Berkeley, CA 94710

Representative:_____

Please complete all information and sign below.

Practitioner Name | Degree

Institution/Practice Name | Dept/Specialty

Address

City | State | Zip

Telephone No. | Fax | Email

Please send me the following information (please be specific):

Practitioner's Signature | Date

Signature verifies that this request for information was unsolicited. Request is not valid without practitioner's signature.