see your skills in sientra.

Medical Inquiry Request Form

Review and submit the completed form to **medical.affairs@sientra.com**

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

First Name:		Last Name:		Title:	
Region:		Product:			

Requested by:	○ MD/DO ○ DMD ○ DDS ○ PharmD/RPh ○ PA ○ CRNA/NP/APRN ○ RN ○ Other

First Name:		Last Name:		Title:	
Specialty:		Email address:			
Institution:					
Address:					
City:		State:		Zipcode:	
Phone Number:		Fax Number:			

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

☐ **Click box if there is an Adverse Event (AE) involving a patient**
ALL AEs INVOLVING PATIENTS MUST BE REPORTED WITHIN 24 HOURS OF RECEIPT

This form is for the documentation and transmission of unsolicited medical inquires to Sientra Medical Affairs. 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 of Sientra.

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

Requestor Signature:		Date:	

(When completing this form electronically, if the requestor is unable to sign, the requestor may type /S/ followed by their full name on the line above)

SIENTRA USE ONLY

Response/Action taken by Sientra			
Name:		Date:	