REQUEST FORM

SIGVARIS GROUP Cares: Compression with a Cause

Sigvaris Inc. 1119 Hwy 74 S Peachtree City, Ga 30269 / Phone 1-800-322-7744 / Fax 800-481-5488

MEDICAL CONTACT INFORMATION

ORGANIZATION NAME: _____

CONTACT NAME: _____

PHONE: _____ **BEST TIME TO CONTACT:** _____

EMAIL: _____

PATIENT CONTACT INFORMATION

PATIENT*(FIRST INITIAL ONLY): _____ **LAST NAME:** _____

ADDRESS: _____

PRODUCTS BEING REQUESTED

CONDITION:

RX included Y or N**

Please include a detailed explanation of your patient's condition and why he / she should be eligible for participation in our program. (Separate paper can be used).

The information provided may be used by SIGVARIS for product endorsement. Sign off for the use of product results in our marketing materials is a requirement for both the patient and provider to participate in the program.

HEALTH CARE PROVIDER: _____ **DATE:** _____

PATIENT: _____ **DATE:** _____

** HIPPA confidentiality*

*** Prescription required for 20-30mmHg and higher circular knit products (ISO 13485 class II medical device)*

**** Limit once in 6 months*

We reserve the right to eliminate or restrict access to this program at any time