



River Falls Medical Clinic

A DIVISION OF WESTERN WISCONSIN MEDICAL ASSOCIATES, S.C.

Also Providing Services at Ellsworth and Spring Valley Medical Clinics

Pharmaceutical Representative Request for Medication Sampling 3/2009

Medication: _____

Pharmaceutical Company: _____

Contact Information: (or attach business card) _____

Date: _____

Please state the reason(s) we should consider adding this medication to our sample list.
(you may also attach additional information to this form)

Our Quality Leadership Committee meets on a monthly basis to review these requests.
We will contact you as to their decision.

Approved for sampling _____ Not approved for sampling _____

Date: _____ Medical Director (signature) _____