

Date: _____
(dd/mmm/yyyy)

Add Your Details			
Title: _____			
First Name: _____		Surname: _____	
Country, <i>specify</i> : _____			
Preferred Means of Contact <i>(may indicate more than one)</i>			
<input type="checkbox"/> Phone	Country code: _____	Area Code: _____	Number: _____
<input type="checkbox"/> SMS/Text	Country code: _____	Area Code: _____	Number: _____
<input type="checkbox"/> Email: _____			
Describe Your Role			
<input type="checkbox"/> Healthcare Professional OR <input type="checkbox"/> Consumer/Patient OR <input type="checkbox"/> Other, <i>specify</i> : _____			
If a Healthcare Professional, please indicate:			
<input type="checkbox"/> Physician			
<input type="checkbox"/> Nurse			
<input type="checkbox"/> Pharmacist			
<input type="checkbox"/> Other, <i>specify</i> : _____			
Select the Product			
<input type="checkbox"/> 25 mg Dapivirine Vaginal Ring			
<input type="checkbox"/> Other, <i>specify</i> : _____			
Describe Your Request for Information <i>(please add as much detail as possible)</i>			

Please submit completed form to medical.information@popcouncil.org

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