25999 SW Canyon Creek Road, Suite C
Wilsonville, OR 97070
Office: (503) 218-2172
Fax: (503) 218-2274

XSTAT MEDICAL LICENSE AUTHORIZATION FORM

The XSTAT device is designated as a "Prescription Only" device, to be used by physicians and/or trained medical professionals only

1 CUTOMER AND SHIPPING INFORMATION

Please Print or Type:

Company Name:_____ **Account #**_____

Contact Name:_____ **E-mail** _____

Authorized Purchaser(s):_____, _____, _____

Address:_____, **City:**_____, **State:**____, **Zip:**_____

Company Shipping Address:_____

City: _____**State:** _____ **Zip:**_____

Telephone:_____ **Alternate Telephone:**_____

*If there is more than one shipping address, please include an attachment with additional addresses.

2 PRODUCT CATEGORY AND LICENSE INFORMATION

I, the undersigned, am the Medical Director or Physician in charge for the above-named facility at the above-specified shipping address. In this capacity, I hereby authorize the purchase and shipment of XSTAT and submit the following referenced license(s) or prescription(s) with respect to such orders, with a copy of such license(s) or prescription(s) attached to this form.

Physician's License or State Board of Pharmacy License #_____**Expiration Date:** _____

3 STATEMENT OF AUTHORITY AND SIGNATURE

I hereby swear under penalty of perjury that (i) I am the (check one)**:** ___ **Medical Director** ___ **Physician in charge; with responsibility for the facility or individual identified above in Part A with respect to the specified address; (ii) that the license and or prescription information provided is current and accurate and I am, therefore, licensed to authorize shipment of the XSTAT to the facility designated; and (iii) I understand that failure to provide complete and truthful information may constitute grounds for the vendor to recommend that appropriate authorities bring disciplinary actions against me.**

Physician Signature: _____ **Date:** _____

Print Name: _____ **Print Title:**_____

Instructions: *This Authorization is only valid if accompanied by a copy of the license or prescription(s) specified in Part 2. This Authorization will expire at the time of the expiration of the above-specified license or prescription(s) (as applicable to the product ordered) or 2 years from submission; whichever comes first. Upon expiration, a new Authorization must be submitted accompanied by the appropriate license or prescription(s) for orders to be processed. If there is a change in Medical Director, Physician in charge, or Authorized purchaser, this Authorization will immediately become void and a new Authorization, including applicable license(s) and or prescription(s), must be submitted for orders to be processed.*

Form Instructions: Please **return this form and a copy of your medical license** via fax, mail, or email to:

RevMedx, Inc
25999 SW Canyon Creek Road
Suite C
Wilsonville, OR 97070
Fax: (503) 218-2274
accounting@revmedx.com