



E-Z Spacer® Demonstration Unit Request Form

Thank you for your interest in E-Z Spacer!

Medical Practice Name

Address

City

State

Zip/Postal Code

Phone

Fax

You have been provided the following sample:

Product	NDC#	Size	Quantity
E-Z Spacer physician demo unit	13551-601-01	ea	1

“By signing this form I certify that I have requested the items listed above in the quantities designated. I further certify that I am a licensed practitioner eligible to receive and prescribe these samples. If I am a Nurse Practitioner or Physician Assistant, I certify that I am authorized and eligible in the state within which I am currently practicing, to request and receive these samples and that I have my supervising Physician’s approval to do so. My signature on this form certifies that I recognize that sample products are for the medical needs of my patients and will not be sold, traded, bartered, returned for credit or utilized to seek or obtain reimbursement.”

Professional ID

BRCID

License Number

State of Licensure

MD DO NP PA Other (Please Specify) _____
Professional Designation

Authorizing Practitioner Name (Print)

Specialty

Authorizing Practitioner Signature (No stamps)

Date

FSC Representative Name

Territory Number

EZ Spacer is manufactured for and marketed by:
FSC Laboratories, Inc. 6000 Fairview Road, Suite 600, Charlotte, NC 28210