



## Authorization Form



Please remember to save this document to your desktop or files upon completion. Changes made to this document will be lost if closed without saving it first!

Patient Name		Country	
Street		Phone (mandatory)	
Postal Code		e-mail	
City			
Physician Name		Date, Stamp (mandatory)	
Street			
Postal Code			
City			
Clinic / Hospital			
Signature	X		

Please return the completed form to

**Customer Service Center I, electroCore Germany GmbH:**

**Loxness Pharma GmbH**

*Registration Hotline*

Hotline: +49 (0) 8171 414-300

Fax: +49 (0) 8171 414-372

e-mail: electrocore\_de@distributioncenter.de

**LOXNESS**  
pharma logistics

Loxness Pharma GmbH

Pfaffenrieder Strasse 5

D-82515 Wolfratshausen

### Internal Use Only

Form received (date)	
Date Customer Created	
Customer ID	