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### Request for Representation – Profile Form

Complete this *Request for Representation* form and return it to the IMDA office in electronic format - as a Word or PDF document. Within 48 hours staff will review the information and post it on the IMDA website in the member's only section. An email will be sent to all IMDA members announcing the *Request for Representation* with a link to this completed form. It will be up to each individual IMDA member to contact you directly about your product. Your RFR will remain on our website for one-year from the date of posting providing additional exposure to your product(s) to new and existing members throughout the year. **This service is free for Allied Members (manufacturer members of IMDA) and \$250 for non-members.**

Date Submitted:		Date representation needed:	
Company:			
Key Contact:			
Street Address:			
City:	State:	Country:	
Postal Code:	Website:		
Phone:	Fax:	Email:	

NAME AND DESCRIPTION OF THE PRODUCT AND/OR PRODUCT LINE:
TARGETED SPECIALTY MARKETS OR CLINICAL DEPARTMENTS:
HAS THE PRODUCT(S) RECEIVED MARKETING CLEARANCE FROM THE FDA? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Pending Date- Submitted to FDA _____
DATE COMPANY FIRST SOLD PRODUCT(S) IN THE U.S. OR CANADA: _____
IF PRODUCT IS BEING SOLD IN U.S. OR CANADA, PLEASE INDICATE CURRENT METHOD OF SALES: W Distributor Independent reps <input type="checkbox"/> Direct <input type="checkbox"/> Mail Order <input type="checkbox"/> Other – Indicate: _____
IF SOLD IN U.S. WHERE IS THE PRODUCT(S) CURRENTLY BEING SOLD:
HAVE PATENTS BEEN FILED ON THE TECHNOLOGY: <input type="checkbox"/> Yes <input type="checkbox"/> No
Check one: <input type="checkbox"/> My company manufactures product(s). <input type="checkbox"/> My company acts as a master distributor.
IN WHAT TERRITORIES (Country) ARE YOU SEEKING SPECIALTY SALES AND MARKETING SUPPORT:

<b>Cost \$250</b>
<b>Payment Information</b> Enclosed: <input type="checkbox"/> Check (payable to IMDA) <input type="checkbox"/> Visa <input type="checkbox"/> MasterCard <input type="checkbox"/> American Express (All payments must be in US funds.)
Account # _____ Expiration _____
Signature _____
<i>Indicates authorization to charge card.</i>

Complete and return to IMDA at [info@imda.org](mailto:info@imda.org) or fax: 630-493-0798.