PHYSICIAN: RISK MANAGEMENT PROGRAMME TRAINING CONFIRMATION FORM

Specifically related to Revlimid® (lenalidomide)

Physician name:	_____________________	**Specialty:**	__________________ __
Hospital:	_____________________	**Address:**	______________________
E-mail address:	_____________________	**Country:**	______________________
Phone: __	_____________________	**Fax:**	______________________

I confirm that:

- I have received the Healthcare Professional Pack specific for my country
- I have received training on the requirements of the Pregnancy Prevention Programme specific for my country
- I understand and agree to comply with the requirements of the Pregnancy Prevention Programme specific for my country

Physician's Signature:	**Date:**

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