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# CTVHCS Pharmacist Appointment Request

Hit the Tab key or click in the next box to use this form.

| | |
|---|---|
| CTVHCS Site | Please select site: |
| Name of CTVHCS Pharmacist (We accept appts Thursdays only 9-11am, 15 minute limit) | |
| Purpose of appointment | |
| Company Represented | |
| Drug Representative Name | |
| Drug representative e-mail | |
| Drug representative phone | |
| Date/time desired | |
| Comments | |