



## Request - Official Transcript from EUROCRINE<sup>®</sup>

I hereby request an excerpt of the information stored in the above registry pertaining to my person

My personal details		
First name and Surname	Personal identification number (if applicable)	Treating Clinic / Hospital / City / Country

### Address

Street.....Street Number.....

City.....

Zip Code.....

Country.....

### Signature

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**Date and signature**

### Request by surface mail to be sent to:

Bettina Pugl, Coordinator EUROCRINE<sup>®</sup>

c/o Vienna Medical Academy

Alser Strasse 4

1090 Vienna

Austria

[office@eurocrine.eu](mailto:office@eurocrine.eu)

**The transcript is sent by recommended post to the address given above by the applicant.**