PHARMACY: RISK MANAGEMENT PROGRAMME
TRAINING CONFIRMATION FORM

Specifically related to Revlimid® (lenalidomide)

Pharmacist name:	
Pharmacy/hospital name:	**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

Pharmacist's Signature:	**Date:**