

WEIGHT LOSS MEDICATION FORM

Please do your best to fill out this form as accurately as possible.
We will notify when the announcement is posted. Please make sure
you check your spelling.

In completing this weight loss medication form please fill out complete names
In Address and locations, please give city state and zip.

Date you want weight loss medication to come out_____

weight loss medication will not be published until receive a date.

If partners are available please list full names of all partners involved

Full names and address of weight loss medication _____

Partners (include address) _____

other partners (include address)_____

Are the weight loss medication partners on the Internet? Yes____ No____

If no list the relationship of the weight loss medication

Company been in business for how long?_____

Partner employed by_____

NAME AND DAYTIME NUMBER (WITH AREA CODE) OF A PERSON AVAILABLE TO ANSWER QUESTIONS

I certify to the best of my knowledge my information is true.

(Name) _____ (Signature) _____

mail completed forms to:
WEIGHT LOSS MEDICATION DEPT
weight loss medication times
po box 391
midland tx 79701