**Scientific Exchange Request Form**

Please complete and submit the Scientific Exchange Request Form 12 weeks prior to requested event date. Each request must undergo a formal review and approval process.

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| **GENERAL EVENT INFORMATION** | | |
| **Event Type** | *Choose an item* | |
| **Event Topic** | *Choose an item* | *Enter additional information* |
| **Proposed Event Date (1st choice)** | *Click here to enter a date* | *Enter additional information* |
| **Proposed Event Date (2nd choice)** | *Click here to enter a date* | *Enter additional information* |
| **Event Location** | *Enter City and State* | |
| **Suggested Venue** | *Choose an item* | |
| **Clinical Specialty/Focus** | *Choose an item* | *Enter additional information* |
| **Business Purpose of Requested Event** | *Choose an item* | *Enter additional information* |
| **Will a Meal be Provided?** | *Yes* | *No* |
| **Estimated Cost ($) of Meal and Venue** | *Enter responsible party to pay and amount(s)* | |
| **Proposed Consultant(s)** | *Enter Last Name, First Name, Title* | |
| **Estimated Duration of Consulting Service** *(excluding travel time)* | *Choose an item* | |
| **# of Hotel Nights Required for event** | *Choose an item* | |

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| **COMPANY/DISTRIBUTOR ATTENDEE INFORMATION** | |
| **Requested Company Attendee(s)** | *Enter requested company attendee names* |
| **Distributor Representative Attendee(s)** | *Enter distributor representative names* |

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| **ANTICIPATED CLINICAL ATTENDEE INFORMATION** | |
| **# of Anticipated Attendees** | *Enter # of anticipated clinical attendees* |
| **Affiliated Hospitals** | *Enter names of hospitals that invitees are affiliated with* |
| **Hospital Locations** | *Enter location (city/state) of affiliated hospitals* |
| **Targeted Hospital Departments** | *Enter names of hospital departments that will be invited to attend* |

*\*Please note that all consultant presentations must be submitted for review by Compliance prior to event\**

Requestor Name: Click here to enter name Date Submitted: Click here to enter a date

\*Submit completed Scientific Exchange Request Form to your AVP/NSM 12 weeks prior to requested date of event

\*Consultant presentations must be reviewed by Kathleen Moon 2 weeks prior to event

**Scientific Exchange Review & Approval Form**

***This section is for internal use only.***

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| **PRELIMINARY EVENT APPROVAL - SALES MANAGEMENT** | | |
| **AVP/NSM Event Approval** | *Yes*  *No* | *Initial/Date* |
| \*Email form to National Director of Surgeon Relationships for review (grs@biocomposites.com) | | |

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| **BUDGET & CONSULTANT USAGE REVIEW – NATIONAL DIRECTOR SURGEON RELATIONSHIPS** | | |
| **Requested Event is Budgeted** | *Yes*  *No* | *Initial/Date* |
| **Recommended Consultant** | *Enter Last Name, First Name, Title.* | |
| **Status of Consulting Agreement** | *Active*  *Expired* | *Expiry date:* |
| **Contract Covers Scope of Scientific Exchange Request** | *Yes*  *No* | *Initial/Date* |
| **Type of Travel Required** | *Choose an item* | *Enter travel origin & destination if applicable* |
| **Estimated Preparation Time**  *(for creation of presentation)* | *Choose an item* | *Enter additional information* |
| \*Email to Director of Marketing, Americas for review (dcl@biocomposites.com) | | |

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| **INTERNAL REVIEW - MARKETING** | | | |
| **Estimated Event Cost ($)** *(non-consultant related)* | *Enter additional event costs* | | *Enter additional information* |
| **Estimated Cost of Consulting Time ($)** *(preparation, consulting services, speaking event)* | *Enter estimated fees* | *Enter additional information* | |
| **Estimated Cost of Consultant Travel Time ($)** | *Enter estimated fees* | *Enter additional information* | |
| **Estimated Cost of Consultant Travel ($)** *(transportation, hotel, etc…)* | *Enter estimated cost of travel* | *Enter additional information* | |
| **Total Estimated Consultant Fees ($)** | *Enter total estimated consultant fees* | *Initial/Date* | |
| \*Print or Email form to VP sales/SVP sales for review | | | |

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| **EVENT APPROVAL - SALES MANAGEMENT** | | |
| **VP/SVP Event Approval** | *Yes*  *No* | *Initial/Date* |
| \*Return form to Director of Marketing, Americas ([dcl@biocomposites.com](mailto:dcl@biocomposites.com)). Marketing will provide approved form to compliance | | |

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| **COMMUNICATION PRIOR TO EVENT – NATIONAL DIRECTOR SURGEON RELATIONSHIPS & MARKETING** | |
| **Communication with Consultant & Requestor Prior to Event** | National Director Surgeon Relationships  *Clinical presentation sent*  *Invoice template sent*  *PDF of work proof requested*  *\*National Director Surgeon Relationships to notify Marketing when complete\**    *Initial/Date:* |
| Marketing  *Notify event requestor to use sign-in sheet*  *Event invitation needed:*  *Yes*  *No*  *Initial/Date:* |

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| **INTERNAL REVIEW PRIOR TO EVENT – COMPLIANCE** | | |
| **Consultant Work Proof Received** | *Yes*  *No* | Date received: |
| **Comments on Initial Work Proof** | *Enter comments here* | |
| **Second Work Proof Received (if applicable)** | *Yes*  *No* | *Date received:* |
| **Work Proof Approved** | *Date of final approval:* | *Initial/Date* |