

Vitamin-fortified, delicious, better-for-you baked goods

HealthCare Professional Registration				Date:
Last Name:		First Name:		
Facility/Organization:			Title:	
Mailing Address:				
City:		State:	Zip:	Unit/Floor:
Phone:	Fax:		Email:	
Please complete entire form. (Check all that apply)				

Where did you first learn about Vitalicious products?

- Magazine/Newspaper Ad
- Patient
- ADA Show/Convention/Local Show
- Colleague
- Search Engine
- Other _____

What kind of facility are you based out of?

- Hospital
- Small Clinic
- Medical Center
- Independent Private Practice
- School
- Other - _____

What are the primary conditions of the patients you consult?

- Pregnancy
- Diabetes
- Weight Control/Loss & Obesity
- Irritable Bowel Syndrome
- Hypertension
- Cardiovascular Disease
- High Cholesterol
- High Blood Pressure
- Renal Disease
- Cancer type _____

Would you recommend our product as ‘ best for _____ ’

- Breakfast Alternative
- Midday snack
- Dessert

Which ingredients motivate you to recommend a particular product?

- Omega-3
- Plant Sterols
- Soy
- Whole Grains
- Resveratrol
- DHA
- Whey
- Hoodia
- Lycopene
- Green tea extract
- Sulphoraphane (broccoli)
- Quercetin
- Pomegranate/ Pomegranate Seeds
- Acai Fruit
- Other _____

What nutritional factors interest you most?

- All Natural
- No Preservatives
- Low Fat
- No Trans-fat
- No Hydrogenated Oils
- Nutraceuticals
- Low glycemic index
- Low glycemic load
- Pre/pro-biotics
- High Fiber
- High Protein
- Organic
- Antioxidants
- Gluten Free

How many clients do you typically meet with weekly?

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Please email completed form to customerservice@vitalicious.com
(Forms must be submitted a minimum of 4 weeks prior to event)

Sample Request

Date of Event (if applicable) _____/_____/20_____

Name/Type of Event_____

Number of Guest Invited/Expected to Attend? _____

How do you intend to distribute the samples? _____

Do you have access to a large freezer to maintain freshness?_____

What other products will you/do you offer as samples?_____

Do you work with Food Service Distributor Programs (i.e. Sysco)? (yes) (no)

Can you order direct/wholesale for your organization? (yes) (no)

Products Requested - Enter quantity next to select product _____dozen Vitalicious VitaTops (2oz)

Same As Previous Page Shipping Address_____

City_____State_____Zip_____Unit/Floor_____

Additional Information

We would like to learn more about your daily responsibilities. Please write a brief summary of your professional experience.

1. Was there/will there be any mention of Vitalicious products in your program/signage/advertising?(specify)

2. What form of recognition will Vitalicious receive from this donation?_____

3. List any other major business donors to your program?_____

4. Please provide us with the names and phone numbers of at least 3 local health food stores in your area.

1. _____ Phone 1()_____

2. _____ Phone 1()_____

3. _____ Phone 1()_____

