Tab 64

CUSTOMER INQUIRY LOG FORM

COMPLAINT #: _____

DATE: 5-22-01 NVE CONTACT: _____

PRODUCT #: 95 PRODUCT NAME: STACKER 2

NVE LOT #: _____ EXP. DATE: _____ UNIT SIZE: _____

NAME: _____

ADDRESS: _____

CUSTOMER #: _____ ORDER #: _____

REASON FOR CALL: RASH - CHEST - NECK
Burning FEELING IN STOMACK.

IF AN ADVERSE REACTION

1. Describe the reaction. _____
2. How many doses taken? 11 PILLS
3. When (time of day) was product taken? MORNING + AFTERNOON
4. Other medicines being taken (prescribed and OTC)? NONE
5. Other existing medical conditions? _____
6. Was dosage taken with a meal? YES.

INVESTIGATION: (as required) _____

DISPOSITION AND FOLLOW-UP REQUIRED IF ANY: _____