


Customer ID:	Customer Name:	
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**Declaration      Fill in ALL lines or fields!!!**

**Декларація      Заповніть ВСІ рядки чи поля!!!**

As a wholesaler, action medeor is obliged to qualify its customers. According to the European Good Distribution Guideline (1013/C68/01) and the German Wholesaler regulation (§6 AMHV) action medeor must ensure that it supplies medicinal products only to persons who are themselves in possession of a wholesale distribution authorization or who are authorized or entitled to supply medicinal products to the public.

**We ask you to complete this document and send it back to [verify@medicalbridge.eu](mailto:verify@medicalbridge.eu) Only after receiving your declaration, we can arrange the delivery to you. Many thanks!**

Organization / institution - Організація / установа:                      public                      private

**English:**

Name: .....

Street no.: .....

Postcode City: .....

**Ukraine:**

Прізвище: .....

Вулиця та номер будинку: .....


Поштовий індекс Місто: .....

Website/ веб-сайт: .....

Please attach for your organization / institution:

Будь ласка, додайте для вашої організації/установи:

- Wholesale license, GDP certificate, pharmacy license and/or
- Proof of establishment (Permissions, licenses)
- Where applicable further information (annual report or other)
- Where applicable proof of non-profit status

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Contact details for any safety issue:

*(Responsible person, pharmaceutical or medical qualification)*

Name: .....

Given Name: .....

Profession: .....

Telephone numbers (landline): .....

Telephone numbers (mobile): .....

Whats App: .....

E-mail Address: .....

Please indicate, where and who the medicines are used:

Medicines are for sale

Medicines are used in humanitarian aid or programs and distributed

for free Medicines are given to patients in my institution

paid                  unpaid

Other (please describe): .....

Recipient hereby confirms to action medeor, that he/she is authorized or entitled by legal or administrative administration to order / receive medicines as wholesaler or to supply to the public.

Date: .....


Stamp / Signature: .....

Recipient hereby confirms to action medeor to inform action medeor about

- any change of the legal or administrative status of the organization / institution with regard to the distribution of medicinal products
- any change of the responsible person

Date: .....

Stamp / Signature: .....

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*To be filled by embassy or ministry:*

The above information has been checked and the facility may be supplied:

.....  
*Date / signature / seal:*



*To be filled in by action medeor:*

Requested by (Name of primary contact at action medeor): .....

Information given checked by (Name of primary contact action medeor): .....

Customer is personally known

Data entry in Dynamics NAV by (Name of primary contact action medeor)

Allocated NAV Client: .....

Allocated Debitor Number: .....

Accepted (Responsible persons of action medeor):

.....  
*Dr. Irmgard Buchkremer-Ratzmann ..... Christoph Bonsmann*

Released in Dynamics NAV (Name and Date) .....